

REPORTING OF EPIDEMIC DISEASES

By WM. C. HASSLER, M. D., Health Officer

A Request to the Physicians of San Francisco:

The Board of Health of San Francisco calls the attention of all physicians of this city to the fact that "Influenza," and its chief complication "Pneumonia," are reportable diseases, and asks an earnest co-operation at this time not only because the law requires the reporting of these diseases, but in so doing a large measure of protection is afforded the civil population.

The menace of an epidemic in this city is very great, communication with the Eastern centers is open and the disease there is rapidly spreading.

Eastern people who were contacts with the disease, convalescents, and carriers are undoubtedly arriving daily, but vigilance and rigid control of new cases and their contacts, especially in the incipient stages, will limit the incidence in San Francisco.

This menace is not to be minimized by the present favorable weather conditions. We are approaching the rainy season and while the epidemic lasts on the Atlantic Coast we must be more expectant of its occurrence here, especially when the weather conditions are more unfavorable and when people are more exposed to its changes.

All reports from Europe point out the fact that home isolation, rest in bed, and rational symptomatic treatment in the first stages, result in rapid and uncomplicated recovery.

Carelessness and indifference results in serious complications and sequelae; pneumonia is most to be feared and is the chief cause of death.

Its onset is rapid, the course severe and the percentage of fatalities high.

The symptoms at the onset of Spanish influenza as recorded in the British Medical Journal dated July 27, 1918, are briefly given as follows:

There are two main varieties of Spanish influ-

enza. One begins with chills or chilliness, which may be slight. There will be what appears to be an ordinary cold, catarrhal, with coughing and sneezing, headache, backache, fever and prostration. The other is marked simply by chills, fever and prostration. Both forms may be marked by nausea and vomiting.

It may be distinguished from those of an ordinary cold by prostration and aches and pains in the head and back. There is no protracted period of waiting to know whether your cold is influenza. If you have it you'll probably know it the first day.

Prophylaxis for Contacts and non-infected:

It is a respiratory disease, therefore mouth, nose and throat hygiene is the primary essential.

A medical officer who claims experience with the disease in Europe states that "powdered Boric Acid" used as a snuff and gargling with Dobell's or similar antiseptic solution, acts as a specific preventive. The solutions are recommended also for nasal douching or in spray by atomizer.

Patients, contacts and nurses should be warned regarding sneezing and coughing, as droplet infection is a direct means of spreading the infection; handling of bed linens, handkerchiefs and other articles of a patient, particularly if of the pneumonic type, are also a means of its spread.

Remedies recommended for the patient vary, but aspirin, the salicylates and quinine are most highly recommended, plus such symptomatic drugs as may be indicated by the complication.

We expect shortly to have a vaccine ready, which physicians can obtain free. Its value while not fully established is reported as preventive.

In times of epidemics every physician should consider himself a member of the staff of the Board of Health and every available facility of the Department is at his disposal.

physician, man or woman, holding the degree of Doctor of Medicine from a legally chartered medical school, who is not now attached to the Government service, and without reference to age or physical disability, may apply for membership and be admitted if qualified; whereas, the original organization admitted only those who for various reasons were ineligible to membership in the Medical Reserve Corps. The organization will mobilize the medical profession in order to provide for the health needs of the military forces and the civil population, and the recording and classifying of doctors will afford means of obtaining quickly men and women for any service required.

To date about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in Government service or have volunteered their services. Up to July 12 the Surgeon-General had recommended to the Adjutant-General 26,733 doctors for commissions in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent. of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty.

The need of using wisely the service of the medical men, in view of the universal war activities, is indicated when it is known that in the five weeks ended August 2 there were 2,700 medical officers commissioned in the Army, Navy, and Public Health Service—or at the rate of 540 per week. It is estimated that at least 50,000 doctors will be necessary eventually for the Army. It can readily be seen that with the enrollment of these active men, their places in communities and institutions must be cared for, and the work, therefore, throughout the country must be so systematized and co-ordinated that the civilian population may not suffer. An important aspect is the need for medical men in the communities where munitions and other vital war products are being made.

The Volunteer Medical Service Corps will thoroughly care for these needs.

IMPORTANT CHANGE IN U. S. EMPLOYMENT CONDITIONS.

The supplying of war industries with common labor will be immediately centralized in the U. S. Employment Service of the Department of Labor, and all independent recruiting of common labor by manufacturers having a payroll of more than 100 men will be diverted to the U. S. Employment Service. This is in accordance with the decision of the War Labor Policies Board and approved by the President on June 17. (The War Labor Policies Board is composed of representatives of the War, Navy, and Agricultural Departments, the Shipping Board and the Emergency Fleet Corporation, the War Industries Board, and the Food,

Fuel, and Railroad Administrations. Its chairman is Felix Frankfurter, Assistant to the Secretary of Labor.)

The above action was found necessary to overcome a perilous shortage of unskilled labor in war industries. This shortage was aggravated by an almost universal practice of labor stealing and poaching.

While the restrictions against the private employment of labor apply only to common labor at the present time, these restrictions will, as soon as possible, be extended to include skilled labor. In the meantime, recruiting of skilled labor for war production will be subject to federal regulations now being prepared.

This drastic change in the Nation's labor program has been found necessary in order to protect the employer and the employed, to conserve the labor supply of the communities and to cut down unnecessary and expensive labor turn-over (which, in some cases, is as high as 100 per cent a week), and to increase the production of essentials. While non-essential industries will be drawn upon to supply the necessary labor for war work, the withdrawal will be conducted on an equitable basis in order to protect the individual employer as much as possible.

A survey of the labor requirements is being made, and in order that each community may be fully protected, rulings have been issued that no labor shall be transported out of any community by the U. S. Employment Service without the approval of the State Director; nor shall any labor be removed by the Service from one state to another without the approval of the U. S. Employment Service at Washington. Every effort will be made to discourage any movements from community to community or state to state by any other service. Farm labor will be protected, for the industrial program distinctly includes special efforts to keep the farmer supplied with labor.

The requirement that unskilled labor must be recruited through the sole agency of the U. S. Employment Service does not at present apply in the following five cases: 1. Labor which is not directly or indirectly solicited; 2. Labor for the railroads; 3. Farm labor—to be recruited in accordance with existing arrangement with Department of Agriculture; 4. Labor for non-war work; 5. Labor for establishments whose maximum force does not exceed one hundred.

When the survey of labor requirements has been made and the aggregate demand for unskilled labor in war work is found, each state will be assigned a quota, representing the common labor to be drawn from among men engaged in non-essential industries in that state.

These state quotas will in turn be distributed among localities. Within each locality, employers in non-war work, including those who are only partially in war work, will be asked to distribute the local quotas from time to time amongst themselves. Quotas by localities and individuals are to be accepted as readily as they are for Liberty Loan and Red Cross campaigns. This plan of labor quotas is a protection for all communities. The object is to keep any community from being

drained of labor, and to use local supply, as far as possible, for local demand. The situation, however, is such that in certain cases some men may have to be transported over long distances.

This is probably the most drastic action that the Government has taken since putting the Army draft into effect. It involves a basic change in the Nation's labor methods, and is significant and important in the present rapid socialization of medical practice.

A NON-ESSENTIAL INDUSTRY.

A non-essential industry of the first magnitude is the manufacture and sale of nostrums and patent medicines. Consider the ingredients which go into their composition, for instance, the alcohol. Food will win the war. Why waste it? Consider the cargo space necessary for their transportation. Why waste it? Consider the army engaged in their production, transport and sale. Why keep them harnessed to a non-essential occupation when there is room in the Army and Navy? Consider finally, the host of users of patent medicines, the gullible host of self-druggers, whose ranks are recruited through credulity and blatant advertising. Seldom, indeed, but that they would profit by freedom from their favorite patent medicine tipples.

It would be well to tax patent medicines to the limit. With such a tax a sincere campaign by drug stores would go far to eliminate this pernicious American habit. Suppose the drug stores did lose money at first. Is that an argument for continued poisoning and swindling of the gullible public? The doctors seem to fight for public health and all it includes, often to their own monetary loss. Why should not the pharmaceutical profession take hold of this thing and oust it?

There is no disguising the fact that some doctors are a disgrace to the ethics and common practice of their profession in that they prescribe nostrums of secret composition. A determined campaign, however, among druggists and physicians would rapidly eliminate such reactionaries in both professions. It is greatly to be desired that patent medicines be ousted, and that the time and money now consumed in their provision and purchase, be diverted to direct war ends. True, as long as money is to be made, nostrums will be produced, and their elimination in this country will simply deluge less fortunate countries with their alcoholic and cure-all contents. Even now arrant fakes and discredited American patent medicines are being advertised and sold wholesale in China. But the civilizing process of popular education will follow them as surely as it may be slowly. For after all, this education in health, wholesomeness and real humanity is the dominating function and excuse for our own profession, and our own nation and our own race.

Says one drug house to its lay patrons, "We do not prescribe for your ills. That's your doctor's business. If you are really ill you cannot afford to take chances with the numerous so-called cure-alls, secret nostrums, or the new home prescription

preparations which are largely advertised. Go to a reputable physician, and if you need any medicine, let him advise you." Would that each doctor would set his own house in order and then confer with his druggists on the suppression of this non-essential, wasteful, unpatriotic and dangerous habit.

DEMOCRACY VS. TIPS.

Scribner's Magazine declared as far back as 1887 that "This whole matter of tipping waiters, and of waiters expecting to be tipped, is a very marked manifestation of the poison of pauperism." A recent newspaper told of the death of a waiter who bequeathed \$30,000. Query: Who is chief pauper, the giver or the recipient of a tip? Doubtless both. Persons and organizations have inveighed against tipping. Its evils have been heralded from the housetops. Its pernicious roots have been diligently excavated. His degrading tentacles have been execrated in song, story and resolution. Its infamous history will not be reviewed here nor will its notorious practice be the theme for condemnation or moralizing. All grant the evil of this ancient pest. All would have its abatement. Few are they who have the personal courage and manhood to stop it for themselves. The expression "manhood" is used with discrimination; for who associates this vice with "womanhood"? Have not we men something here, too, for study and learning?

Out of the great war have come certain good things. Others are dimly scanned in the misty future. As a war measure, alcohol is nearly eliminated. May the elimination be permanent! Equal suffrage has advanced mightily; fraternity, liberty, equality have become a ruling passion among men; venereal disease and prostitution are being attacked as never before in history; socialization of medicine is progressing by leaps; democracy is become a motive in the average man's breast. The war has furnished the stimulus, and the occasion—yes, even the excuse—for the accomplishment of many excellent and needed programs for human betterment. Why not, then, as a war measure, abolish tipping? What though it be one of our national and best-loved vices? We admit its evil. We agree that it is incompatible with democracy. Why not make occasion of the war to root it out? We are tearing from us the vastly better entrenched liquor vice. Here is another of the cult of nuisances. Let's away with it.

Abolish tipping as a war measure? Certainly. Let it be widely understood that no man in uniform is expected or allowed to give a tip. Let waiters and hat check persons and all other parasitical exponents of the upward palm feel that they are un-American and disloyal to the great vibrant spirit of democracy, if they under any circumstances accept a tip from a man in uniform. That much we ought to do and enforce. Then who would be a tipper and thus prejudice equal service to the man in uniform? No tips expected from men in uniform and none given. That is at least a good start.

THE HEALTH OFFICER AND THE WAR.

It is said to take nine men working "over here" to keep one soldier fighting "over there." Clearly, therefore, it is wise to keep the nine workers husky and working as well as the one soldier.

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, October 14-17, to be held under the auspices of the American Public Health Association. Among the military sanitarians who will address the meetings are Surgeon-General Gorgas, Colonel Victor C. Vaughan, and Major William H. Welch of the Army Medical Corps. There will also be papers upon laboratory, industrial hygiene, vital statistics, food and drugs, sanitary engineering, sociological, and general health administration subjects. Other speakers at the general sessions will be George H. Vincent, president of the Rockefeller Foundation; Dr. Charles J. Hastings, president of the American Public Health Association; Dr. W. A. Evans, Assistant Surgeon-General Allan J. McLaughlin, U. S. P. H. S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, Dr. Frederick L. Hoffman and others.

As the health of the civil population has a direct bearing upon the winning of the war, mayors and governors are being requested to send their health officers to the conference in spite of the present high cost of government.

URGENT NEED FOR NURSES.

Surgeon-General Gorgas has called for 1,000 graduate nurses a week. Twenty-five thousand graduate nurses must be in war service by January 1—in the Army Nurse Corps, in the Navy Nurse Corps, in the U. S. Public Health Service, and in Red Cross war nursing. This involves withdrawal of many nurses from civilian practice and necessitates strict economy in the use of all who remain in their own communities. You can help get these nurses for our sick and wounded men by bringing this need to the attention of nurses. You can relieve nurses, where possible, wholly or in part from office duty. You can see to it that nurses are employed only in cases requiring skilled attendance. You can insist that nurses be released as soon as need for their professional service is ended. You can see that your patients use hospitals instead of monopolizing the entire time of a single nurse. You can encourage people to employ public health nurses. You can instruct women in the care of the sick. You can induce high school and college graduates to enter the Army School of Nursing or some other recognized training school for nurses. Encouraging nurses to go to the front involves real personal sacrifice and added work on the part of the physicians whose duty it is to maintain the health of our civilian second line defense. But the men who are fighting for their country in France need the nurses.

EDITORIAL COMMENT.

Secretary McAdoo has received the following cablegram from General Pershing:

"All ranks of the American Expeditionary Forces appreciate deeply the generous measure the Government has taken to provide insurance for their families, in proof of which more than 90 per cent. of men have taken out insurance. To wisely provision for their loved ones heartens our men and strengthens the bonds that unite the Army and people in our strong determination to triumph in our most righteous cause."

The Bureau of War-Risk Insurance up to June 28 has written \$21,566,000,000 insurance, representing 2,570,455 applications. The average amount of insurance applied for is \$8,387, and in some battalions and regiments, some in France and some here, every man has taken out insurance. In some units every man is insured for the maximum \$10,000.

The *American Review of Tuberculosis* for July comments editorially on the safety first philosophy for the tuberculous. The man with arrested tuberculosis has to face, besides the popular stigma, the alternative of a life of idleness, in itself fraught with dangers of mental and physical deterioration, or venture along a risky path watching for symptoms of relapse, often too serious when once begun. There is only the middle ground for such a man which he must find for himself and be vigilant and well controlled. No test exists as yet to indicate the degree of healing of a tuberculous lesion. Many cases are discovered in persons in apparent good health and it would seem reasonable to consider that they have already demonstrated their physical fitness to continue their occupations. Such cases should receive an education and be allowed to continue in their usual vocations unless these are frankly hazardous. Intelligent caution is sufficient and until the attitude of the public is more reasonable and less hostile to the tuberculous, such instruction ought to be as free from publicity as possible. Much distress of mind may thus be prevented and the knowledge of, or the accidental discovery of, the disease will lose some of its dread significance to the hitherto unsuspecting individual.

NOTICE.

The Pulp and Paper section of the War Industries Board find it necessary to use every effort to conserve the paper supply and to reduce the consumption as much as possible. One of the requirements is that all publishers discontinue all free and exchange copies of their publications. The CALIFORNIA STATE JOURNAL OF MEDICINE is co-operating with the Board and is complying with this request, and we feel sure that this situation will be appreciated. If any of our readers to whom we have heretofore been sending free or exchange copies desire to receive our publication we will be pleased to place their names on our mailing list if they will send us \$1.00 in advance, the price of subscription.

Special Article

THE DENTAL INITIATIVE.

By DEAN GUY S. MILLBERRY, University of California
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At periodic intervals the people of our commonwealth are asked to decide, by ballot, questions of general and individual interest. Prior to 1910 these questions were presented in the legislative halls, referred to committees for consideration and public hearing and decided by the representatives of the people. Since 1910 we have reserved unto ourselves the right to enact legislation directly by means of the initiative, referendum and recall.

This method, found to possess a power which would yield a great good, has also been found to possess the means of promoting selfish individual interests for those who, if willing to spend the necessary money, may bring an issue before the people.

That the initiative was never intended for these latter purposes, no one will deny. That it is being used for such purposes is apparent in an analysis of the proposed dental initiative amendments and the arguments favoring their adoption.

The issue is known as Initiative Amendment No. 21 or the dental measure. A synopsis of the amendments together with an analysis of them follows.

The act is entitled "An act to insure the better education of dental surgeons and to regulate the practice of dentistry in the State of California," etc. The proposed amendments should be entitled "An act to destroy the present high standards demanded of the dental profession by the people, in order that the selfish interests proposing the amendments may be greatly enriched thereby."

The malice inspiring this measure is shown by the fact that the proponents waited until the dental profession was distracted by the war. Practically all of the recent graduates and many of the younger men within the first draft age limits in dentistry are in the service of the nation. The majority of the other members of the dental profession are giving freely of their time in rendering a much needed service to the recruits and drafted men gratuitously. And this is the time selected to introduce this vicious measure.

The amendments are numbered Sections 17 to 20, inclusively.

Section 17 of the proposed measure provides for the creation of a Board of Dental Examiners of seven members, each of whom must have received from a recognized College or University a degree other than a dental degree, and that no member of the board shall hold office for more than four years within any six years.

It is presumed that, by this proposed change, a dentist with only a dental degree is incompetent

as a member of the board to determine the fitness of candidates entering his own profession. If such be true the same regulation would hold in all professions. As a matter of fact the largest percentage of teachers in our dental schools possess only the dental degree, and American dental schools are generally acknowledged to be well recognized institutions throughout the world.

Familiarity with the duties and problems in vocational board service is necessary if the membership of such a board would render good service to the state, and the rigid or lax enforcement of health laws depends largely upon a knowledge of conditions gained by experience as board members.

We believe that the real motive of this section is to dispossess a Dental Board so thoroughly well informed on the tricks and subterfuges of the illegal practitioners and the charlatans that they dare not openly violate the law.

Section 18 provides that the Secretary of the State Board of Dental Examiners, upon application, shall issue a license *without examination* to any person who shall (1) pay a fee of twenty-five dollars; (2) show that he is of good moral character; (3) must be a graduate of a reputable dental college recognized by the National Board of Dental Faculties; (4) has been examined and licensed by a Board of Dental Examiners of any state of the United States; (5) has practiced under the laws of any state of the United States for a period of five years next preceding the filing of his application in this state.

This section is the real motive for presenting the measure, and the purpose is cleverly concealed under the plea that justice and equity is not meted out to dentists who would like to come to California from elsewhere and engage in practice.

To justify the statements that California demands good dental service and maintains high standards let me say that out of forty-seven dental colleges in the United States, of which only fourteen are Class A schools, there are two Class A and one Class B schools located in this state, and that California has more dentists in proportion to the population than any other state in the Union except Vermont and the District of Columbia.

If this measure becomes a law the standards of California will be reduced to the level of the lowest standards in the country and the requirements for admission to and graduation from our high grade dental colleges will be stultified, for persons may go to any other institution with lower standards and after practicing elsewhere for five years come to this state and practice without examination.

As a matter of fact if the initiative is passed we might just as well acknowledge that this state is incapable of setting up standard qualifications for the practice of dentistry, and that our universities and colleges are not qualified to establish and direct the courses of study necessary to educate the youth of the Pacific Coast in dental science. Our dental schools should close their doors and discontinue the work they have done for nearly forty

years in providing dental service for the people of this state.

The purpose of this section is to permit dentists to come here from elsewhere who can not pass a fair examination in order that the wholesale dental offices can secure more labor at probably less cost. This simply means the exploitation of labor.

The result will be that the incompetents and derelicts from elsewhere will flock to California and on demand will be admitted to practice. The public will not be protected, for the authorities now appointed by law to pass judgment on all dentists will not be allowed to determine the fitness of these individuals and they will be allowed to practice unconditionally. The public will have no recourse whatsoever if inefficient or incompetent dental service is rendered.

Statistics show that the migratory dentists are usually the incompetents, who because of their inability to establish and hold a practice in any community are continually seeking new fields; while the competent, well trained, modern, up-to-date dentist does not object to an examination in any state because he knows the people need such protection.

Further the measure demands that the graduates of our own high grade dental schools must pass an examination while those coming from other states after five years of questionable practice are not required to do so. There is no reciprocity established since the licensed dentists of this State can not go elsewhere and practice without examinations, while men may come here from elsewhere and do so.

The Surgeon General of the War Department at the present time is urging a plan whereby a method of national or reciprocal licensure will be established on a basis of standard qualifications. It would be folly in the face of such a proposal to enact a law now that would require an enabling act and initiative procedure to correct, in order to conform to the above plan.

Section 19 provides that any person shall be guilty of a misdemeanor and punishable therefor, who shall in the practice of dentistry administer any anesthetic except in the presence of an adult third person.

This is merely a slur on the dental profession. It does not protect the public against the dangers arising from carelessly administered anesthetics by incompetent persons, but it will add materially to the cost of dental service by requiring the presence of a nurse at all times, whether the occasion or the community needs demand it or not. It must not be construed that the dental profession is opposed to the presence of a nurse but that there is no need for such legislation and for making it a misdemeanor to operate without the presence of a third party.

Every dentist to protect himself against a violation of the law must employ a nurse who must be present at all times. Her absence through illness would prevent the dentist from rendering a humane service to his patient as it would also do in emergencies. The third person present except

it be a member of the dentist's staff is often a source of responsibility diverting the attention of the operator from the patient at a critical time.

Section 20 provides that nothing in this act shall be construed to mean that it is unprofessional to advertise or that the charging of low fees for dental work shall be deemed unprofessional conduct.

This section shows the hypocritical character of the measure for there is nothing in the present law to prevent advertising and fees for professional service cannot be regulated by law.

All of the professions have for many decades refused to advertise their personal qualifications and attainments because such methods savored too much of egotism and conceit. There is no more reason why the dentist should advertise than should the lawyer or the carpenter.

Chester H. Rowell, one of the foremost editors of California, in commenting on this feature of the proposed measure has said: "This reference to advertising is designed as a bribe to newspapers to support the measure. It illustrates a contemptuous attitude of mind toward the newspapers on the part of the proponents of the measure and should be promptly resented by every self-respecting man in journalism."

In summarizing, the less one knows about ill-health or disease the more necessary it is that they be treated by well-trained physicians or dentists, for the uninformed are much more likely to be taken advantage of by the unskilled and unscrupulous, and thereby harmed both in body and in purse.

If initiative legislation can be enacted by a single individual through deception and misrepresentation for his own personal enrichment and to the detriment of the health of the state, then the status of all public health legislation is in great danger.

Should this measure pass it will become necessary to resort to the initiative and an enabling act procedure to modify the dental law in the future. Public health legislation faces the same problem if this passes.

The whole measure is vicious. It will, through pretense and deception, lower the standards of dental practice. It offers the alluring promise that dental service will be less expensive, an appealing but untruthful statement because fees for professional service cannot be regulated by law. It offers no protection to the people against incompetent and unscrupulous dentists for the laws are designed and enacted to protect the people and not the dental profession. It will add to the cost of dental service by making the employment of a nurse a necessity. It is proposed and financed by a single individual whose public philanthropies are as yet an unknown quantity, but whose personal interests appear to be the predominating purpose in this issue.

It is an effort to prostitute a great agency of the people, the initiative, and to degrade and besmirch an honorable profession for personal gain.

The intelligent electorate of California will vote an emphatic NO on Amendment 21.

DR. JOHN GALLWEY'S ARGUMENT AGAINST COMPULSORY HEALTH IN- SURANCE.

(From the San Francisco Examiner, September 15, 1918.)

The people of this State are called upon to decide at the polls on November 5 whether California shall change its Constitution and adopt Compulsory Health Insurance. This proposition will appear on the ballot as No. 20.

Like all members of the medical profession, questions affecting the public health demand my earnest consideration. After an impartial and painstaking examination of the alleged data and arguments offered by the Social Insurance Commission of California and a careful review of the history of compulsory insurance from its German origin to the present day, I have reached the firm conclusion that its adoption by California would be a grave and costly mistake.

With all its enormous cost, Compulsory Health Insurance fails to produce practical results, but it inevitably demoralizes, cheapens and undermines the ethics and standards of our profession and hopelessly handicaps necessary research work.

As our profession is dedicated to the cause of public health, whatever jeopardizes our interests imperils the interests of the public proportionately.

The military genius of Germany evolved the scheme to make dependents more dependent.

My disapproval of Compulsory Health Insurance is not based upon the fact that it was "made in Germany." Its origin, coupled with its purposes and perverted ethics, however, make us more careful now in investigating this alien than we were in 1915, when Compulsory Health Insurance first appeared as an applicant for our state adoption.

CLAIMS COSTLY FAILURE.

Much strong evidence that it has not only been a disappointment but a costly failure in Germany might be adduced, although it served the temporary purposes of the military clique. To-day the American mind, however, regards German statistics with just suspicion—a nation that wantonly broke its most solemn pledges and ruthlessly violated sacred treaty obligations, contemptuously calling them "mere scraps of paper"—cannot be trusted to furnish other scraps of paper covered with laudatory statistics that may be relied upon.

I find it difficult to diagnose the specific kind of Compulsory Health Insurance with which our Social Insurance Commission wish to inoculate California, because the members of the commission refuse to give us a laboratory specimen. We do not require a laboratory test, however, to state definitely that all forms of Compulsory Health Insurance are dangerous in this climate and results would be generally fatal.

Even if a leopard is covered by a spotless robe, we still adhere to the belief that his spots are unchanged.

I believe we should be impressed by the uniform rejection of Compulsory Health Insurance by all the States that have considered it. If it has any substantial benefits to confer it would naturally

be most welcome in the congested manufacturing centers of the East, where climatic, health, housing, living and wage conditions compare so unfavorably with California. The recent action of Massachusetts in repudiating this measure by a decisive vote is, therefore, especially significant. For California—the nation's health resort—heedlessly to become the first experimental state for Compulsory Health Insurance would indeed be an anomaly.

ADVISES DELAY.

There are so many of our able doctors at the front to-day, as well as keen observers from all walks of life, who now have exceptional opportunity for acquiring first hand valuable information on such doubtful vital subjects as Compulsory Health Insurance, that prudence suggests we refuse admittance to this alien applicant until our boys return from Berlin.

I am aware that the excessive zeal of the advocates of Compulsory Health Insurance has induced them to publish and proclaim this foreign measure as "imperative" for the success of our war program. As an extravagant statement for an extravagant measure, the commission's "war" statement is extremely unique.

But this is no time to engage in extravagant statements or experiments. All our time, talent and treasure should be exclusively devoted to winning the war. The increasing demands of our boys and allies make the practice of personal and public thrift our patriotic duty.

Such funds as we may have that are not required by the essential war activities should be devoted to a constructive policy for the conservation of public health, recommended by our foremost American health authorities—a policy based upon scientific facts, devoted to all the people, not to special classes.

WOULD NOT REDUCE SICKNESS.

More than sixty per cent. of disease is preventable.

The practical preventive policies proven by practice produce permanent results for the benefit of all. The ineffective sickness relief policy of Compulsory Health Insurance, whilst it would burden the many for the benefit of the few, would not remedy the destitute, reduce sickness or offer anything but palliatives.

And in exchange for a few palliatives, we are asked to adopt a Compulsory Health Insurance policy in California that would give a Social Insurance Commission arbitrary powers and make it superior and not accountable to courts, executive or people.

It would enable the functionaries of the commission, to which this vast power was granted, to pry into private homes, decide the state hospital to which the compulsory insured should be taken when sick and destroy the sacred confidential relations between physician and patient.

Many English doctors, impelled by the just objections of patients, are rebelling against the ruthless operation of the Compulsory Health Insurance Act requiring a description of private diseases to

be spread before the public eye upon the public records.

The vital defects of Compulsory Health Insurance are so apparent, and the need of it so invisible, and the objections to it so serious and the cost of it so enormous, that the only answer I can conscientiously give to the commission's question—"Shall we have Compulsory Health Insurance in California?"—is emphatically "No."

Original Articles

CEREBROSPINAL FLUID FINDINGS IN HERPES ZOSTER.*

By W. F. SCHALLER, M. D., San Francisco.

Herpes Zoster is divided into acute specific Herpes and symptomatic Herpes. The former classified and studied by Head and Campbell¹ and later experimentally by Rosenow and Oftedal² is claimed by these latter observers to be due to a streptococcus. It has for its characters that it is obtained from the tonsils, from the sputum, from pyorrheal cavities; that morphologically it is non-capsulated, stains positively by Gram, is short-chained and often lanceolate; that it produces moist green colonies on culture. In animals Rosenow and Oftedal produced typical Herpes lesions, both centrally and peripherally by intra-peritoneal and sub-cutaneous injections. The injection material included in addition to pure culture of the streptococcus, mixed cultures from the tonsils and pyorrheal cavities, and emulsions of tonsillar tissue. The posterior roots or ganglia corresponding to the Herpes area on the skin showed hemorrhages and edema. The hemorrhage at times extended for a short distance along the sheath of the spinal nerve, but intercostal nerves and cutaneous branches remote from the lesions in the ganglia and skin showed no changes. Streptococci in the clear blister fluid were absent. These primary mild lesions are probably trophic; the severer lesions are probably the result of a superimposed hematogenous infection. The streptococcus of Herpes Zoster has, then, an elective affinity for the ganglia and posterior roots. The skin lesions are probably at first trophic.

Symptomatic Herpes has been noted as a complication of a variety of different conditions, amongst which may be mentioned pressure cord paralysis as from tumor (Boas³), as an accompaniment of pneumonia; Pott's disease; poisons, such as arsenic; different forms of cord and meningeal disease; disease of the spine, such as carcinoma. Alderson⁴ reports a case of Herpes in relation to a syphilitic cord lesion. Immerman⁵ reports two cases of paresis and one of tabes showing Herpes, and concludes that the ganglion changes were in all probability specific due to spirochetes or their toxins.

Of the numerous theories of the causation of Herpes the lesions in the spinal ganglia and consequent trophic skin changes appear to be the most tenable. Of all those nervous disorders in which

trophic changes occur from well-defined central lesions, such as tabes, syringo-myelia, as typical examples, Herpes has always appeared to me to be the purest example of a trophic nerve lesion. In tabes, for example, Barré⁶ has held that the arthropathies are really due to vascular changes in the joints. Eloesser,⁷ from animal experimentation, holds that the so-called trophic changes underlying Charcot joints are due to trauma and disturbance of the protective sensory mechanism of the extremities by reason of the sensory system degeneration. The frequency of syphilis in cases of syringo-myelia may also explain in a large measure the trophic changes secondary to vascular disease. Recently von Tschermak⁸ has reported a case of gangrenous Herpes following a partial lesion of the brachial plexus affecting the ulnar nerve fibres, the eruption occurring after a period of 109 days after the injury. This writer regards this instance of Herpes to be a late angio-neurotic reflex. Similar cases have been previously reported by Charcot, Brown Sequard, Weir Mitchell et al. Orr and Rowe⁹ believe Herpes to be an affection of the ganglia from an ascending process by way of the nerve lymphatics of the nerve sheaths. Montgomery and Culver¹⁰ hold that the infection travels from the periphery, the door of entrance being the skin or mucous membranes. Accordingly Herpes is a centripetal disease. Thusly motor complications of Herpes and especially the frequency of these in cephalic cases are explained. Hewlett¹¹ states that the cause of motor paralysis accompanying Herpes is by no means clear. In two cases of cervical Herpes reported by this author and complicated by facial paralysis on the same side, the most plausible explanation appeared to be a descending process along the cervical nerves from the affected ganglia, and extension to the motor terminations of the facial nerve and an ascending process affecting the nerve trunk itself.

It seemed to me as far back as 1912 that one met with Herpes in syphilitic disease with uncommon frequency. The possibility of supposedly specific Herpes being in reality due at times to a latent syphilis was next thought of. Accordingly we endeavored to make cerebrospinal fluid examinations in all cases of Herpes which presented from that date. Of 79 cases of Herpes a lumbar puncture was done in 21 cases. In 14 cases in which a blood Wassermann alone was done four cases showed a positive reaction and 10 a negative reaction. The remaining 44 cases were not examined by the blood or fluid tests, nor were they clinically cases of syphilis.

The following brief abstracts of 21 cases in which the fluid was examined are here given. Only the routine tests for analysis of the fluid were made. There were no examinations for bacteria nor attempts at culture.

1. W. R. Dispensary No. 13197—12. Male, aged 38. Tabes. Dermatitis herpetiformis. Eruption on left buttock following salvarsan administration. Wassermann: blood negative, fluid positive. Leucocytes 88 per cmm. Globulin increased.

2. M. S. Dispensary No. 15742—13. Male, aged 41. Syphilis, Herpes Zoster. Eruption D₁₂ L₁ L₂ L₃ right side. Wassermann: blood positive, fluid

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negative. Leucocytes 100 per cmm. Globulin increased.

3. J. H. Dispensary No. 1466—11. Male, aged 7. Syphilis, Herpes Zoster. Eruption D₁₀, D₁₁ right-sided. Wassermann: blood positive. Fluid Noguchi positive. Leucocytes not given. Protein increased.

4. B. D. W. Dispensary No. 9643—Male, aged 22. Herpes Zoster. Eruption D₁₀, D₁₁ left-sided. Wassermann: blood and fluid negative. Leucocytes 2 per cmm. Globulin not increased.

5. C. A. Private records (Relief Home). Male, aged 74. Herpes Zoster. Eruption D₁₀, D₁₁, D₁₂ right-sided. Wassermann: blood positive, fluid positive. Leucocytes 10 per cmm. Globulin increased.

6. Incomplete record; history misplaced; data from card index. J. Male. Herpes Zoster. Cerebrospinal fluid findings. Globulins not increased. Leucocytes 2 per cmm. No record of Wassermann.

7. H. F. Dispensary No. 14915—13. Male, aged 58. Herpes Zoster. (History of chancre followed by specific treatment in 1887.) Eruption D₁₀ right-sided. Wassermann: no record. Leucocytes 14 per cmm. Globulins slightly increased.

8. C. P. Dispensary No. 23439—Male, aged 30. Herpes Zoster. Eruption C₁, C₂ left-sided. Wassermann: blood and fluid negative. Leucocytes 90 per cmm. Globulin slightly increased.

9. W. P. Dispensary No. 19913—Male, aged 60. Herpes Zoster. Eruption supra-orbital region right-sided. History of soft chancre 41 years ago, followed by specific internal treatment. Wassermann: blood and fluid negative. Leucocytes not increased. Globulin not increased.

10. N. S. Dispensary No. 48881—Male, aged 44. Cerebro-spinal syphilis. Herpes Zoster. Eruption fourth to ninth rib on right side of spine. Wassermann: blood negative. Fluid positive in amount of 0.5 ccm, negative 0.1 ccm. Leucocytes 73 per cmm. Globulin increased.

11. M. B. Dispensary No. 50418—Male, aged 56. Pulmonary tuberculosis, arthritis of spine, Herpes Zoster. Eruption, location not given. Wassermann: blood and fluid negative. Leucocytes not increased. Globulin not increased.

12. L. L. Dispensary No. 4757—Female, aged 8. Congenital lues, Herpes Zoster. Eruption left chest and back. Wassermann: blood positive. Fluid, no record. Leucocytes 63 per cmm. Globulin slight increase.

13. T. D. Dispensary No. 51332—Male, aged 54. General paresis, Herpes Zoster. Eruption D₁₀ left side. Wassermann: blood positive. Fluid positive. Leucocytes—three different fluids 55, 68, 70 per cmm. Globulin increased.

14. A. C. Dispensary No. 52713—Male, aged 41. General paresis, Herpes Zoster. Eruption on left shoulder. Wassermann: blood and fluid positive. Leucocytes 10 per cmm. Globulin increased.

15. A. J. Private Records 373—Male, aged 61. Pneumonia, Herpes Zoster. Eruption maxillary branch of 5th nerve. Wassermann: blood negative, fluid negative. Leucocytes 10 per cmm. Globulin negative.

16. A. P. Dispensary No. 44695—Male, aged 48. Herpes Zoster. Eruption lower intercostal nerves, left sided. Wassermann: blood negative, fluid negative. Leucocytes 6 per cmm. Globulin negative.

17. G. M. Dispensary No. 51918. Male, aged 11. Herpes Zoster. Eruption on posterior trunk. Exact distribution not given. Wassermann: blood and fluid negative. Leucocytes 2 per cmm. Globulin negative.

18. H. E. Dispensary No. 61775. Male, aged 76. Herpes Zoster, arteriosclerosis, hypertension. Eruption over 6-7-8 ribs right side. Wassermann: blood and fluid negative. Leucocytes 10 per cmm. Globulin negative.

19. B. B. Dispensary No. 59940. Female, aged

48. Syphilis, Herpes Zoster, chronic hypertension. Eruption left lower abdomen. Wassermann: blood positive, fluid negative. Leucocytes 1 per cmm. Globulin negative.

20. H. H. Private records (Relief Home). Male, aged 85. Herpes Zoster. Eruption left lumbar distribution. Wassermann: no record in blood and fluid. Leucocytes 14 per cmm. Globulin negative.

21. D. R. T. Private Records, No. 994. Male, aged 35. Herpes Zoster. Eruption inner border of right foot. Wassermann: blood and fluid negative. Leucocytes 15 per cmm. Globulin slightly increased.

Of the foregoing cases 9 occurred in syphilitic persons and in all but one of these (No. 19) the fluid showed a characteristic reaction of syphilis of the central nervous system. Eleven cases were negative for syphilis. However, in 5 out of these 11 cases there was a cellular increase above the normal—cases Nos. 8, 15, 18, 20, 21. The globulin test in these 5 cases was negative or slightly increased. One case (No. 7) we must class as doubtful as regards presence or absence of syphilis.

The following comment may be made from the foregoing analysis:

1. Herpes Zoster occurs with comparative frequency as symptomatic Herpes in syphilis of the central nervous system.

2. In non-syphilitic Herpes an increased cell count may mislead the clinician if other evidence suspicious for syphilis is brought out in the general survey of the case. As an example of this, I wish to mention more in detail the last case in my series. The patient, a physician, complained of pain in both lower extremities, which was suggestive of either the lancinating pains in tabes or an alcoholic neuritis. A blood Wassermann reaction revealed an xx-reaction. A searching neurological examination revealed, however, no sign of central nervous system syphilis. A lumbar puncture and fluid examination showed a negative Wassermann, reaction, globulin slightly increased and leucocytosis of 15 cells per cmm. Repetition of the blood Wassermann gave a negative reaction. Additional medical history in this case brought out the fact that a slight herpetic eruption had occurred about two weeks before the patient presented himself for examination. Even at this time evidence of the Herpes lesions were seen on the outer border of right foot.

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IS PURGATION JUSTIFIABLE?

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Dr. Alvarez has written several papers purporting to show that purging patients before surgical operations is the only cause of the peristaltic disturbance commonly known as "gas pains." He thinks the surgeons have been "striving for false ideals" and that they purge their patients in a perfunctory and unintelligent manner, "*ut aliquid fieri videatur*," so to say, on account of superstition; without knowing what they are doing, without even being able to explain and justify the procedure. If this were so it would certainly reflect on the intelligence of the surgeons; therefore it seems proper that we should go into this subject with more detail.

The first remark to be made on Dr. Alvarez's papers is that the author fights against many things that exist solely in his imagination and not in reality. Surgeons abandoned excessive purging many years ago (see Kocher, *Operative Surgery*, 1907), and only an ignorant surgeon would physic his patient the evening before the operation so as to disturb his last night's sleep. Also, no sane surgeon administers physics to acute cases of appendicitis or Meckel's diverticulitis, acute peritonitis and the like. Therefore, any objection to their doing so was perfectly unnecessary and could have been omitted altogether.

But, coming to the subject proper, we think that Dr. Alvarez has weakened whatever is right in his contention by falling into a manifest exaggeration. He says, for instance, that no purgatives should be given because some purgatives are irritants and cause *dehydration*. To this the layman would answer that there are still some physics that empty the bowels gently, without causing any irritation or *dehydration* whatever, for instance, castor oil. Then why not use these?

The author seems unable to judge the relative importance of the various facts under consideration; he gives great prominence to observations that carry no weight and have no value as proof; and he deliberately ignores other facts that have the greatest importance and are the real crux of the whole problem. To illustrate this: he states that purging and ether alone have caused paralytic ileus in some cases. I have witnessed thousands of anesthetics and I have never come across anything of this sort, and most surgeons are of the same opinion. Why then give such prominence to, and attempt to use as decisive proof, a fact that is so very rare that everybody will doubt it?

But the main fault I find with Dr. Alvarez's work is the way that he has consistently ignored the factor that dominates this whole subject, and that we surgeons know is the real cause of gas pains: I mean the trauma we inflict on the peritoneum and abdominal organs in the course of our operations. I am surprised that Dr. Alvarez should give so little thought to this; and his experiments have certainly been conducted in a manner most unfair to the surgeon, and far remote and totally dissimilar from the conditions met in human surgery and pathology. He states that many laparotomies did very well without purgatives. I think

that they would have done equally well after taking a mild physic. Simple abdominal operations do well and cause little pain when there is little pathology and little intra-abdominal manipulation; but they all have gas pains when the operation is long, difficult, and attended with much handling of the intestines. Therefore, if Dr. Alvarez wants to convince us he should pay more attention to human surgery and should try to reproduce the same conditions in animals. He should first perform a long and difficult operation—say a gastrectomy, resection of the intestines, hysterectomy or the like—on the animals, and preferably in cases where tough adhesions had been created some months previously; then a day or two after the operation he could study peristalsis, and if he should find it normal in such cases we would be ready to dispense with the use of purgatives.

Surgeons are always skeptical about experiments performed on healthy or on dead rabbits, and they maintain that what they have observed in hundreds of operations performed on human beings has also some experimental value, at least for the diseased human body. But if rabbit experiments are to prove anything at all, they should be conducted under conditions as nearly similar to human pathology as possible in order to allow fair and rational conclusions.

That a trauma of any kind inflicted on muscular tissue will impair its function, is well known and sufficiently established by the following instances: the paresis and relaxed condition of the anal sphincter for several days after its dilatation; the transitory bladder incontinence after confinement, when the urethral sphincter has been crushed against the pelvis by the child's head; the often very obstinate paresis of the descending colon after operation on the kidneys, etc. The most extreme example of this is seen in abdominal surgery, in the traumatic paralytic ileus. I saw such a case a few years ago; a young man in perfect health fell from a wagon and landed on his stomach, on hard ground; the next day there was much vomiting and distension of the abdomen. (By the way, the man had not been prepared by purging!) A laparotomy was performed; the whole intestine was found distended and paretic; there was no other lesion, no mechanical obstruction of any kind. The man died two days after the operation from paralytic ileus.

Every abdominal surgeon knows that the handling of the intestine, no matter how gentle, will be followed by some functional disturbance proportionate to the length of time, the severity of the procedure, etc. While this intestinal paresis may be trifling in a case of hernia, early (unexploded) appendix, or simple gastroenterostomy, etc., it becomes more and more pronounced in all the difficult cases where the intestine or rectum is adherent to pus tubes, an old diseased appendix with peritoneal adhesions, etc. That explains why an unprepared acute appendix case does so much better (regarding gas pains) than a well prepared interval one!

How does the surgeon explain "gas pains"? We think that a coil of intestine that has been

handled during the operation remains inactive ("paretic") for some time; the intestine above that point, being functionally normal, tries by healthy contractions to force its contents through the paralyzed segments. These contractions, by pulling and twisting the mesentery, cause what the layman calls gas pains. It seems logical to admit that a muscle recovering from a temporary paralysis will find it easier to make a little effort rather than a great one at first; this is why we believe that preliminary emptying of the bowels will make the work easier for the intestine recovering from paresis than if it has to forward heavy fecal masses. But this is of secondary importance; the main point is, that the long handling of the intestine, *the trauma*, is the main factor responsible for the partial intestinal paralysis and for the consequent gas pains, and that the preparation has little to do with it.

Now it is very kind of the physiologist to tell us to handle the tissues gently. (I thought the surgeon found this out first, years ago!) It is certainly an axiom for us to practice the "feather-like" dissections whenever we can do so. But this is not always possible in human surgery. You can do it in healthy men and animals; but in old peritoneal adhesions, when you have to dig two or three coils of small intestine away from the Douglas space, do the necessary repairs, stitch defects in the serosa, do an anastomosis, a resection, etc., as may be necessary, you will find in spite of all gentleness, that you have inflicted on the intestine a tremendous trauma of one and a half or two hours' duration; and these are the very cases which make so much trouble afterward, no matter how they have been prepared.

From the foregoing considerations we are forced to conclude that Dr. Alvarez has not proved his point, and this chiefly because he has ignored or overlooked the *corpus delicti*, which is the trauma done the intestinal muscles in every abdominal operation. This being so, and until experiments on this question are conducted in a manner duplicating the real conditions of human surgery, we feel at liberty to continue to purge our patients if there are other good reasons for doing so.

Far be it from us to give a physic before operation out of reverence for the teachings of the old humoral pathology (most surgeons nowadays hardly know of such a thing). Nor is it our remotest intention to interfere with the normal metabolism of our patients or to combat auto-intoxication. We know that it is most unsafe to venture into a ground that is not familiar to us. We purge our patients simply and solely to insure cleanliness and asepsis on the operating table; the surgeon does not want to be half sure, or nearly sure about this; he must be absolutely certain that the patient's bowels will not move on the operating table when the sphincters are relaxed, which is bound to cause infections, either by direct contact in operations around the rectum and pelvis and lower limbs, or indirectly by upsetting all the work of the nurses and the aids in the operating room.

We are told that the small bowel empties itself

in nine hours and that the colon can be cleansed by enemas. These are fine *ex cathedra* statements, based on laboratory findings but ignoring the psychic element in man. In practical surgery we often have people who are very neglectful about regulating their bowels—laborers, miners, etc.; they tell us that their bowels move regularly, yet in emergency operations (without preparation) we find the cecum full of feces which, in cases of intestinal work, would certainly endanger the suture. In other patients who had taken a mild physic we have found the cecum still quite full at the time of operation, even in cases where enemas had been given. I have had cases where the operation was delayed half an hour or more because the patient could not return an enema given an hour previously. When this can happen under nervous excitement, why could not a similar disturbance in the emptying of the intestines take place the day before an operation? Enemas alone are not sufficient to insure perfect cleanliness in surgical operations. This is conclusively proved by many emergency cases prepared only by enemas, and in which feces escape through the relaxed sphincter, as is often seen during operations for perirectal abscesses, infiltration of urine, colpoto-mies, etc.

The Kocher school, to which I have the honor to belong, still continue to give a laxative before the operation. We give a mild physic, castor oil or a moderate dose of salts, *forty-eight hours* before the operation, in order to do away with the possible accumulation of feces that occurs in cases unknown to us. The day before the operation the patient has soft food and even a little bismuth. The night before he has only liquids; on the morning of the operation he is given a large enema, not so early as to disturb his sleep. This preparation, with mild purging forty-eight hours before the operation, while not conforming to new physiological discoveries, has worked very well for many years. It does not weaken the patients; does not disturb the peristalsis, and insures us against soiling the operating table. It is not done as a senseless routine *ut aliquid fieri videatur*, but as a matter of principle, to guard against anything that might endanger the asepsis. In short, we can say that in the last ten years surgeons have reduced purgation to the minimum compatible with safety to the asepsis.

Another point: We are told to feed patients as late as possible before an operation. How late? I have known nervous patients who, on the morning of the operation, vomited light food taken the night before.

We are told to feed patients early after operations; this also requires some explanation. I admit that they should not be starved for a whole week. But as long as gas pains, due to intestinal paresis, exist with the consequent reverse peristalsis, as indicated by distension, vomiting, or even only nausea, no attempt should be made to give anything by mouth, as this will only cause more vomiting, and no physiological experiment will prevail against the firm conviction, born of experience, of the surgeon on this point. Enemas are useful after operation because, in emptying the lower bowel of all

its contents, they make it easier for the parietic segment to recover and resume its activity gradually, without working against resistance.

As to the use of the Murphy drip, no physiologist should ever pass on this admirable method who has not himself operated on serious abdominal cases in man. As long as the intestinal paresis with nausea and vomiting persists, the Murphy drip should be continued; not only will the water be absorbed quickly in very large quantities (insuring a sufficient supply of water to the circulation) and without distress, but it will tide the patient over the dangerous period until the intestine returns to its normal activity.

The mild physic we give when the condition improves may not be so necessary; but to the surgeon's mind, after a serious abdominal operation, it is like the "proof" we make after adding long columns of figures. It shows that everything is certainly right. Besides, moving the bowels early after an abdominal operation is probably the best means at our disposal of preventing the formation of adhesions.

To sum up: The physiologist who deals solely with normal peristalsis in healthy rabbits, making an incursion into surgery, thinks that prevention is everything and that doing away with physics will bring the millennium in abdominal surgery. But the surgeon who, by the trauma of the abdominal operation, himself creates (necessarily and unavoidably) in every case more or less intestinal paresis due to the handling of the gut, no matter how gently, is interested chiefly in relieving the condition which exists, and which will always exist, more or less, as long as intestines remain involved in the pathology of the abdominal organs.

Avoid forcing food into patients who are still nauseated from their reverse peristalsis; avoid provoking vomiting, which can only lead to exhaustion and loss of liquids. Extensive use of the Murphy drip for thirty-six or forty-eight hours, or more if necessary, to insure an ample quantity of water to the circulation; enemas to empty the lower part of the bowel. These are well-tried means which no surgeon would like to miss.

In serious cases with threatening stercoraemia and exhaustion, protracted vomiting, etc., from paralytic ileus, an electric enema has often been a powerful stimulant to the parietic intestine and has saved many patients in especially desperate cases, which fortunately are rare.

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Remark. Since this article was written a paper by Dr. Emge appeared in the J. A. M. A. (Sept. 14, 1918), bringing some clinical facts in support of Dr. Alvarez's theory. This paper shows that a physic administered too late will cause a lot of discomfort to the patient. That is easily understood. The exaggerated peristalsis set up by the physic and the peristaltic disturbance (paresis) of the lower bowel caused by the operation are antagonistic and this is bound to cause much pain. The physic given too late intensifies the gas-pains.

This does not prove that it is the cause of these pains. The only conclusion to be drawn from Dr. Emge's paper is: No purgative should ever be given the night before an operation. Those who make it a rule to give no physic later than 48 hours preceding the operation do not observe any gas-pains in ordinary cases.

PUBIOTOMY.*

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Cesarean Section because so technically simple has won such a high regard in the opinion of general surgeons, general practitioners, and even many specialists in obstetrics, that often more rational obstetrical operations are disregarded. Pubiotomy is one of these operations, and while it can not compete with Cesarean Section in a large field, in a small field it has much to recommend to those especially trained to manage abnormal obstetrical patients.

It is the purpose of this paper to point out that in at least three groups of cases pubiotomy is a more preferable operation than is Cesarean Section, to describe briefly the technique most often employed in performing the operation, and to give the prognosis for mother and child.

Before taking up the indications for the operation, it will perhaps be helpful to mention the contraindications. Since pubiotomy is always performed in the interest of the child, it should never be done when the baby is dead or in imminent danger. This last can often be determined by attention to the foetal heart rate. If this rate is below 100 or is markedly irregular, pubiotomy should not be done.

If the foetal heart be slow or irregular, it is wiser to attempt a high forceps and if unsuccessful, do a craniotomy as it is not justifiable to subject the mother to a bone-cutting operation to deliver a child which in the majority of cases would not survive the shock of the operation.

The second contraindication is furnished by contracted pelvis in which the conjugata vera is 7 cm or less. In these cases, it would be impossible to deliver a normal sized child without seriously injuring the sacro-iliac joints.

Finally in those cases where infection is manifestly present, it is not wise to do the operation.

INDICATIONS.

Group one: There are certain cases where a slight disproportion between head and pelvis exists but where one might expect spontaneous labor to occur. This disproportion may be the result of a large head, showing no signs of hydramnios, with a pelvis which is normal. Or what is seen more often, the head is normal in size and the pelvis is somewhat smaller than normal.

Spontaneous labor occurs in about 75% of all such cases. In the remaining cases, even several hours of second stage pains with ruptured membranes fails to bring about sufficient descent of

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the head into the pelvis and we are confronted with the choice of pubiotomy, high forceps or craniotomy. Cesarean Section at this stage is attended with such high mortality that it can scarcely be considered. When both mother and child are in good condition, pubiotomy becomes the preferable procedure. It is wise, however, to put the saw in place, then apply the forceps or do an internal podalic version, and if gentle traction does not bring the head into the pelvis, the bone should be cut through. After severing the bone, extraction of the child is easy.

ILLUSTRATIVE CASES, GROUP ONE.

Case 1. Mrs. H. O., No. 14269-13. Age 27 years. Gravida III, Para II.

Last Menstruation.—August 5, 1915, making expected date of confinement May 12, 1916.

Previous History.—Negative except for previous pregnancies and labors.

Previous Pregnancies.—Two uneventful.

Previous Labors.—First one March 1913. Duration 34 hours. Terminated by high forceps. Baby still born, weight 9½ pounds. Second one, July 1914. Duration 26 hours, terminated by version and extraction. Baby born alive but lived only a few minutes. Weight 9½ pounds.

Recovery uneventful in both cases.

Present Pregnancy.—Uneventful.

Pelvic measurements:

Spines	24
Crests	25
Trochanters	31.5
Left Oblique.....	21.5
Right Oblique.....	20.
External Conjugate.....	19.5
Diagonal Conjugate.....	11
Bisischial	9½

Pelvis.—Flat.

It was decided to watch patient carefully and to induce labor before the baby became too large as there seemed to be slight disproportion between the head and pelvis. On May 9th, as patient showed no inclination to go into labor a bougie was introduced. A few pains resulted but patient did not go into active labor. Nine hours later, the cervix was about one-half dilated, with thin edges. Pains had ceased in spite of the administration of quinine (15 grs.) The disproportion did not seem great, so it was decided to complete the dilatation of the cervix manually and do a version and immediate extraction.

In view of the past obstetrical history it was deemed wise to lay a saw and if difficulty was experienced in the extraction to do a pubiotomy. This was done according to the method described later.

When the extraction was begun, it became evident that the child was larger than had been anticipated and it was difficult to get the thighs down. The pubiotomy was then done and a very easy extraction followed.

The upper wound was closed, a small drain placed in the lower wound and the patient's hips tightly strapped with adhesive. There was no communicating tear into the vagina. Catheterization showed clear urine. Baby weighed 10 lbs. and was 51 cm. long. Mother and baby left hospital on May 31, 1916, in excellent condition.

The only increase in size of the pelvis which was noted at the time of discharge was in the bisischial diameter, which measured 11.5 cm.

Case 2. Mrs. V. S., No. 19569. Age 31 years. Gravida VIII, Para VI.

Last Menstruation.—Some time in February, 1916, one month after last confinement, making expected date of confinement doubtful.

Previous History.—Negative except for previous labors.

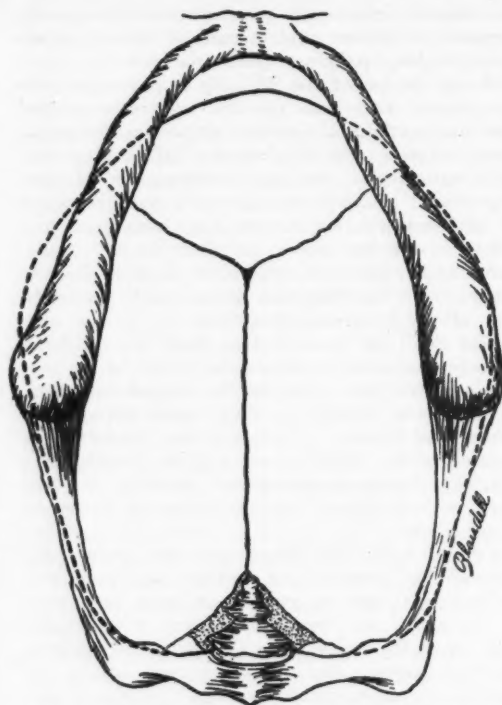


Fig. 1—Funnel Pelvis. Bischial diameter 7 cm. Post. Sagittal diameter 5 cm.

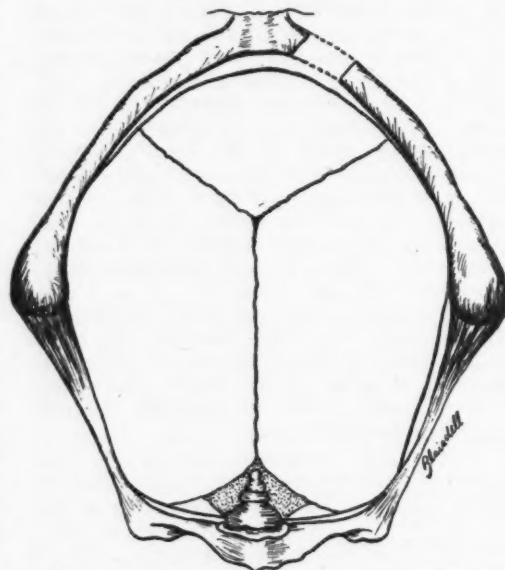


Fig. 2—Same as Fig. 1 after Pubiotomy. Bischial diameter 10 cm. Post. Sagittal diameter 5½ cm.

Previous Pregnancies.—Uneventful except for one spontaneous abortion 8 years ago.

Previous Labors.—Of the first four labors, three babies died at time of labor. The fifth baby was born in Lane Hospital in December, 1914, after an attempt at high forceps, by a very difficult version. Weight 8 2/16 lbs. Baby lived. The sixth baby was born in Lane Hospital in January, 1916, after long second stage, by version. Weight 10 lbs., length 56½ cm. Baby alive but suffered with Erb's

Palsy and a depressed fracture of left parietal bone.

Present Pregnancy.—Uneventful.

Pelvic measurements:

Spines	28
Crests	30
Trochanter	34
Right Oblique	24
Left Oblique	23½
External Conjugate	20
True Conjugate (estimated)...	10
Bisischial	10

Pelvis—Flat.

Patient entered hospital April 5, 1917, in labor. Fundus measured 40 cm. above symphysis indicating very large child. Head not engaged. First stage of labor lasted 27 hours. After two hours of second stage pains and with ruptured membranes it was decided to terminate labor by Internal Podalic Version. A pubiotomy saw was placed as a prophylactic measure. Under anaesthesia the promontory was found to project forward at a sharp angle, the true conjugate was estimated at about 10 cm. After turning child it was found impossible to deliver the head and the pubis was severed. Baby born in good condition, weighed 8 13/16 lbs., length 53 cm. There were no lacerations. Mother and baby dismissed April 21, 1917, in good condition.

Group two: There is a second group of cases in which pubiotomy is usually the best possible procedure; namely, in those cases with funnel pelvis. Here the bisischial diameter of the outlet measures 8 cm. or less.

Williams of Baltimore has called special attention to this group and finds that in his clinic the contraction occurs in about 8 per cent. of all women. The contraction may occur independently or be associated with a contraction of the superior strait as well. Spontaneous labor does not depend in the true funnel pelvis on the bisischial diameter alone but also on the posterior sagittal diameter which is the distance from the mid point of the bisischial diameter to the tip of the sacrum. If this diameter be long enough, spontaneous labor may occur even when the bisischial diameter is as short as 5.5 cm. It has been shown that in this type of pelvis the enlargement following pubiotomy reaches its maximum and very often following the operation a normal pelvis results. This would be most desirable in young women, as a spontaneous outcome could be expected in future labors.

So far, there have been no pubiotomies performed in the Stanford Women's Clinic for this indication. Several patients with funnel pelvis have been delivered by Cesarean Section at the onset of labor, some of whom might possibly have delivered themselves after a test of labor, while some patients have been delivered by forceps. In the future it is the intention to recommend to patients with funnel pelvis that they submit to the passing of a saw prophylactically and to have pubiotomy done if necessary.

Group three: The third group of cases at times requiring pubiotomy are patients with breech presentations who have a slight disproportion between pelvis and head.

When the head presents at the superior strait one can usually determine with a fair degree of accuracy whether engagement and finally spontaneous labor will occur. When the child presents

by the breech, however, this is not so simple a matter, and if external version can not be performed there is no way of knowing whether engagement can be effected even with an attempted breech extraction. When the pelvis is slightly contracted and the patient primiparous the matter becomes quite a deal more complicated and may result in a futile attempt to deliver a living child or in craniotomy on the aftercoming head. Confronted with the above situation one should wait for complete dilatation of the cervix, then prepare the patient for a breech extraction and pass a saw behind the pubis before attempting to extract. If the extraction then offers no great difficulty, the saw can be removed and the wound closed. If difficulty arises in the delivery the bone can be quickly severed and the child can be delivered safely. The saw should always be passed first, however, as one has not sufficient time to do so if the child has already been extracted as far as the head.

ILLUSTRATED CASE, GROUP THREE.

Mrs. A. W., private patient of Dr. A. B. Spalding. Age 24. Gravida 1, Para 0.

Last Menstruation.—August 7, 1915. Labor due May 14, 1917.

Previous History.—Negative.

Present Pregnancy.—Negative. Life felt Dec. 6, 1916, at the 17 2/7 week.

Pelvis normal.

Patient entered Lane Hospital May 18, 1917, in labor. The presentation was frank breech L.S.A. After 19 hours and 15 minutes, the cervix was fully dilated, membranes unruptured, frank breech still above brim. The membranes ruptured after 25 minutes of second stage pains. As the patient was very anxious for a live child she readily consented to have a pubiotomy saw passed prophylactically. The saw was passed, the perineum dilated manually, a partial internal podalic version was done and the patient allowed to deliver herself, which she did in 28 minutes. The saw was removed without sawing the bone and the incision closed, including a laceration of the perineum. The baby weighed 7 14/16 lbs. The mother and baby made an uneventful recovery.

In the clinic, so far, no patients in this group have been helped with a pubiotomy saw, and as a result several babies have died that could have been saved by this operation.

The technique usually followed in doing the operation is that described by Doederlein in 1904. After cleansing the patient thoroughly and emptying the bladder by catheter a small incision is made parallel to and slightly above the pubic bone. This is usually done on the left side but there is no particular advantage in this.

Care should be taken to cut down just medial to the pubic spine. If one goes too far laterally injury may be done to the large vessels (obturator and femoral) and also to the attachment of Poupart's ligament. Likewise one must not do a symphysiotomy, but keep far enough away from the symphysis to leave a small bony segment.

A special curved needle, resembling an aneurysm needle, is passed behind the bone and pushed through the labium majus. The saw is fastened to this, and the needle withdrawn, leaving the saw in position behind the bone. The bone can be sawed through with only a few movements. At

this stage a fair amount of hemorrhage occurs, controlled by pressure. The bone usually separates about 3 cm as soon as cut through. In order to protect the sacro-iliac joints, it is wise to have an assistant stand on either side and make pressure over the hips so the gaping does not exceed 6 cm. Forceps or version can then be accomplished.

Following the operation the bladder should again be catheterized to determine the presence of injury. The upper incision is closed by suture and a small drain is placed in the incision in the labium.

An adhesive strap about 4 inches wide should be put tightly around the hips holding the cut edges of the bone as nearly together as possible. The patient should then be placed on a Bradford frame to facilitate handling. After a few days the patient can be removed from the frame and usually is up and walking by the end of the third week.

The prognosis is good for both mother and child.

The mortality rate is not higher than 3 per cent. in cases done by experienced operators. Williams reports 43 cases without a death. Rongy reports 28 cases with one death, the patient dying of gangrene of the foot.

The largest number of cases have been reported by Schlaflí, who collected from the literature 700 cases done by 142 operators. The maternal mortality was 9.6 and the foetal 4.8. The maternal mortality here is unquestionably high and can be attributed to the large number of operators.

A series of 319 cases done by well-recognized operators was reported in 1907 with maternal mortality of 1.88 per cent. and foetal of 4 per cent.

Of more interest, however, are the complications which may occur and which are considered as serious objections by those who are opposed to the operation.

First to be considered, are injuries to the bladder and urethra. If one is not careful to have the bladder empty before passing the needle and in cases of cystocele to hold the bladder away from the needle, it is easy to injure either bladder or urethra. I have seen two such injuries, one in which the needle was passed through both walls of the bladder, but the mistake was discovered before the saw was used. Fistulae did not develop and the bladder healed spontaneously. The second case had a small fistula which healed within three weeks. There was one fistula in Rongy's series.

Communicating tears are seen in about 20 per cent. of the cases. These should be immediately repaired, and in the cases seen while in Williams' Clinic, all did well.

Hemorrhage may be rather profuse when the bone is severed. This, however, is usually venous and can be controlled by pressure. If the bleeding is persistent the wound should be laid open and the bleeding vessel ligated.

Some of these cases have experienced slight difficulty in walking immediately after leaving the hospital. In none of the cases I have seen has this persisted more than two months. It has been extremely interesting to see how free from trouble these patients are, when we realize they have a movable segment of bone in their pelvis. This

will be better appreciated from the X-Ray slides which will follow.

From the above then, it seems justifiable to conclude that:

1. Pubiotomy competes with Cesarean Section, only in a limited class of cases.
2. Pubiotomy is often indicated in:
 - a. Moderately contracted pelvis where test of labor fails to bring about spontaneous birth and when both mother and child are in good condition.
 - b. Funnel pelvis of pronounced degree especially in young women. The effect on the pelvis here is often such as to leave the outlet normal.
3. Patients having large babies presenting by the breech, or with borderline pelvis and a breech presentation where one can not be sure as to the presence of disproportion between head and pelvis.
3. The prognosis is good for both mother and child, when the operation is done by experienced operators in well-equipped hospitals and in cases where both mother and child are in good condition.

Lane Hospital.

A CONTRIBUTION ON FOCAL RENAL INFECTIONS.*

By LEON JOSEPH ROTH, M.D., Los Angeles.

This report is based on six selected cases, all showing certain similar constitutional symptoms and wide variance regarding local manifestations and end results. The purpose of these histories is to demonstrate the uncertainty regarding the course of infection, pathological processes and terminology of a not uncommon condition. Bacilli of the colon type were found in five cases, but differed widely as to number, and it is very apparent that the severity of the actual bacillary infection is in no way parallel to the symptoms or to the local and general manifestations. A curious fact exists that no casts were demonstrable except in one case (Mrs. E. F. T.), and even then only a few hyaline and epithelial were found after a thorough search.

Case 1. Mrs. T. H., age 23. Patient seen in consultation only. Has recently recovered from a tonsillar infection and since has been having night sweats (about one week). Temperature 103 plus. No pain except during the period of frequent urinations. There exists a characteristic bacteriuria of colon type. General physical appearance very good. Except the tonsillar, has no other discoverable septic foci. Patient has been under a routine treatment. The urine cleared and her symptoms disappeared after about ten days when she returned to her home.

B. B., age 4. No definite history obtained on account of ignorance of parent. Child actually suffering from nasal and pharyngeal infection. Urinations frequent and painful. Rectal temperature 105. Urine gives characteristic swirl of bacteriuria and microscopically shows myriads of bacilli of colon type. No membrane in throat, no eruption on body; vulva inflamed. This child died about the seventh day of its illness.

Case 3. P. M., male, age 25. Has never been

* Read before the Forty-seventh Annual Meeting of the Medical Society of the State of California, Del Monte, April, 1918 (Genito-Urinary Section).

ill or had any infection except gonorrhea six years ago, from which he fully recovered. A year after there developed a urethral burning without discharge, which recurred if patient drank hard or overworked, and was always accompanied by the passage of a fine gritty substance, which occasionally appeared in small masses at the end of urination. These masses were composed of pure cocci mixed with some undetermined inorganic substance.

Examination: Physical condition perfect. No genital pathology. Bladder negative except for few collections of white substance at fundus. Separate specimen of urine showed very numerous staph from both sides. Radiography negative. Following pelvic lavage and an autogenous vaccine, the urine became limpid, but was showered with fine particles which rapidly sunk to the bottom of graduate, and which microscopically showed the persistent cocci. The patient voluntarily discontinued treatment, being more interested in the urethral condition than the bacterial. This case does not properly belong in this group. It is included on account of the fact of having no recognized focus of infection, unusual infective bodies, no demonstrable pathology and no symptoms outside of the urethral burning.

Case 4. B. C., male, age 24. History of ordinary diseases of childhood. Has not been confined to bed for any illness for many years. No history of previous focal infection. Appears now with his first Neisserian infection of seven weeks' duration, and moderately severe reaction, including a left epididymo-orchitis, and a fairly severe prostatitis. He has had several attacks of moderate urethrorrhagia, which began about the fifth week of his infection. No pain had existed previous to this. There have been no chills or fever. Actually a persistent discharge exists, not great in the morning, but mostly during the day. Microscopic examination shows many pus cells and many intracellular diplococci. (Gram stain.) The urine is badly infected. Day urinations two or three; night urinations four to six. Has had pains recently in both renal regions, but these disappeared shortly after the ingestion of methyloids was discontinued. There existed a sub-chronic cystitis with granulations at fundus, the irritated mucosa showing tendency to exfoliation. The examination was rapidly made on account of clouding of the field by pus. Specimen of separate urines showed much pus and many gram negative intracellular diplococci. An intravenous injection of phthalein done at this time showed a very slow and very weak output, appearing in about ten minutes and in such minimum quantity that no estimate of percentage was made. There have been no casts and no albumen. The quantity of urine secreted was approximately normal and the specific gravity about 1014. A roentgenological examination revealed no evidence of stone or other pathology in the urinary tract.

Diagnosis: Bilateral Neisserian pyelitis or pyelonephritis and possibly ureteritis. Treatment: The kidney pelvis have been irrigated three times, at weekly intervals with a 2 per cent. silver nitrate solution, and a pure Neisserian sero-bacterin administered in increasing doses, with the result that the patient's urine has cleared to normal.

Case 5. Mrs. B. N., age 28. Early history unimportant. Married three years ago. Less than two weeks after, and at time of first postmarital menstruation, developed dysuria, frequency and terminal haematuria. These symptoms lasted a few days and went into an indefinite and not clearly remembered sub-condition with pelvic pains following later. Otherwise there have been no illnesses. About three weeks ago there developed a severe tonsillitis, which kept patient in bed for several days. Had been fairly well for three days when dysuria, frequency, and terminal haematuria again appeared. Seven days ago pains developed in an insidious manner in the right renal region,

which persisted, plus high temperature, into renal colic, and was accompanied by greater urinary discomfort and an increased amount of bleeding which was fairly copious, particularly during the painful crisis. (Mrs. E. F. T., No. 7.)

Examination: Temperature 104; great muscular rigidity on right side, plus severe pain. Cystoscopy showed normal bladder. Thorium injection showed ptosis of right kidney, but both pelvis are normal; 10 cc. capacity on right, 13 cc. on left. Examination of separate specimen of urine and excretion of phthalein shows as follows:

Microscopical.			
Left.		Right.	
Pus	None	Loaded	
Blood	Many—Catheter trauma	Many	
Bacteria	None—No T. B.	Few bacilli—No T. B.	
Casts	None	None	
Crystals		Many phosphates	
Functional Tests.			
Phthalein	Intravenous 1 c.c.		
Time appeared	13½ min. (reflex inhibition)	8 min.	
1st period	¼ hr. 9%	¼ hr. 1%	5
2nd period	¼ hr. 7½%	¼ hr. 1%	5
Total	½ hr. 16½%	½ hr. 2%	
Polyuria	Water 3 VIII	No apparent result	

Note the paradox of the infected kidney excreting phthalein more rapidly but in much less quantity than its opposite. Her physician reports daily diminution of temperature following the examination with a drop to normal about a week later.

Diagnosis: Right infective pyelitis, possibly pyelonephritis. Treatment routine.

Case 6. Mrs. E. B. T., age 36. Early history unimportant. About twenty months ago had ten days' attack of gripe from which she fully recovered. Two months later had tonsillar abscess which was lanced. Following this and up to nine months ago was fairly well but not strong, and has had occasional chill and sweats. At this later date went to bed with the so-called gripe, and remained bed-fast until three weeks ago. It was at this time, January 27, 1917, that patient first noted mass in left side. Urinary frequency developed. Six and seven urinations both day and night. It developed that this frequency was only relative on account of the large amount of fluids ingested. The urinations were imperious in character, with burning during the act and with terminal spasms. No bleeding. The patient does not complain of pain, but only a fulness on left side and no polyuria following relief from this. Nausea is constant.

Examination: Patient very emaciated, weighs about 80 pounds; temperature as high as 104; large mass on left side, the lower pole of which is below the anterior spine of the ilium; upper border reaches the costal margin. Right kidney is normal in size, but descended so that it can be grasped between the fingers. Lungs normal. No T. B. demonstrable either in sputa or urine. Wassermann negative. Blood count: Reds 3,230,000, whites 13,360, polys 82%, lymphocytes 18%.

Cystoscopy. Bladder negative. Separate specimen obtained, and phthalein and pyelography done. The results of these examinations are as follows:

Urinalysis.			
Left (Pathological side)		Right.	
Quantity	10 c.c.	12 c.c.	
Microscopical.			
Pus	Very few 1 or 2 to field H. d.	Rarely a W. B. C.	
Blood	Few	Very few	
Bacteria	Very few	None	
Casts	None	None	
Crystals	None	None	
Epith.	Many small	Few—small round and squamous	
Note rarity of pus cells on diseased (left) side.			
Functional Tests.			
Phthalein	1 c.c. Intravenous		
Time appeared	3½ min.	2½ min. (very active)	
1st period	15 min. —7%	15 min. —20%	
2nd period	15 min. —4	15 min. —8	
Total	½ hr. 11%	½ hr. 28%	
Polyuria	Two glassfuls water during examination.		
	Right kidney more active—about 2 to 1 on left.		

A left nephrectomy was done on 7-18-17. No

complications encountered and the patient made a rapid recovery. Pathological comment. No tumor formation. Numerous pus filled abscesses.

Diagnosis: Left suppurative nephritis. Ptosis of right kidney with moderately tortuous ureter.

Case 7. Mrs. E. F. T., age 62. Early history indefinite. Three children previous to her 21st year, and a fourth when about 40. Health supposedly good during interim. Three years after birth of last child had pain on left side, for which was cut-retted; and following this during an attack of pain, discharged considerable pus and blood through vagina. Had recurrent attacks until menopause at fiftieth year. When 53 developed an infection supposed to be the grippé. During the persistence of temperature, she would spontaneously void a great deal of pus and blood in the urine and the attacks would then subside. The temperature was accompanied by great dryness of mouth and a urinous odor of the breath and dysuria. Repeated attacks of the same character occurred up to the time of consultation, except that the microscopic haematuria had ceased, but the pyuria persisted. When first seen was very weak and emaciated and running a high febrile course. During her examination, cystoscopy showed no bladder pathology except the ordinary senile changes. The results of urinalysis and phthalein tests are as follows:

Urinalysis.		
Left.		Right.
Urea	1.8	0.9
Microscopical.		
Pus	Many—10-15 per field	Many—15-20 per field
Blood	Very few	Very few
Bacteria	Few in clumps	Few in clumps
Casts	Few hyaline and epithelial	Few hyaline
Epith.		Many small cells
Functional Tests.		
Phthalein	1 c.c. Intravenous	
Time appeared	8½ min.	10 min.
1st period	15 min. 13.0%	15 min. 7.5%
2nd period	15 min. 11.5%	15 min. 10.0%
Total	¾ hr. 24.5%	17.5%

Remarks: The Phthalein test is high considering the fact of having had kidney pathology for over nine years. The pyelograms are interesting inasmuch as the patient has never complained of renal pain. Diagnosis, chronic pyelonephritis of infectious origin, plus deductions as to cause of hemorrhage and renal deformity. Treatment: No doubt the drainage of the kidney pelvis have been productive of some benefit. Her physician has been using coli vaccine, a proper amount of induced polyuria, urotropin and hygiene with the result that at present the patient is in splendid condition without fever but with persistent pyuria of low grade.

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THE PREVALENCE OF STREPTOCOCCAL INFECTIONS.*

By RACHEL L. ASH, M. D., San Francisco.

The purpose of this paper is to call attention to the prevalence of streptococcus in epidemic or sporadic form in our community, with septic sore throat as the original focus of infection and the involvement secondarily of other parts of the body, particularly the respiratory tract.

Streptococci were seen as early as 1866 by Rindfleisch in the pus formed during suppurative inflammations, but their pathogenic significance was first strongly emphasized in 1881 by the work of Ogston, who differentiated streptococci from staphylococci; by Fehleisen, who in 1883 isolated the streptococcus erysipelas (hemolyticus); and by Rosenbach in 1884. The importance of the strep-

tococcus outweighs all other disease producing organisms in their relation to human infection.

Owing to the variations in morphology, cultural characteristics and virulence, it has been exceedingly difficult to differentiate distinctly the various types. The first classification was based on morphological characteristics and pathogenicity (i. e., long or short chains, capsules, etc.) but later investigations have proved that classification based on biological characteristics are more reliable in determining type, because of the influence which environment has on morphology.

The classification of Schottmüller is the most practical for clinical purposes. He classified streptococci into three great groups: (1) Streptococcus pyogenes or erysipelas, which shows hemolysis on blood agar plates; (2) Streptococcus viridans or mitior, which produces a green halo about the colonies on blood agar plates; and (3) Streptococcus mucosus, which produces a dark green zone around colonies on this medium. Streptococcus mucosus, about whose classification there has been, and still is, considerable discussion, is probably identical with pneumococcus Type III of the now well known classification of the Rockefeller Institute. Here the gram positive diplococci causing pneumonia are arranged according to their immunological characteristics into four types: Types I and II are invariably pathogenic, Types III and IV are commonly saprophytic, sometimes pathogenic.

Epidemics of sore throat were reported as early as 1875 in South Kensington, England, and between 1880 and 1905 there were ten epidemics reported which were fulminating in character. The first epidemic of sore throat studied in America was that of 1911 in Eastern Massachusetts by Winslow. Here the records of over 1500 cases were collected, from 1100 to 1200 of which were in the immediate region of Boston. During the same period in a district some 20 miles distant about 392 cases occurred. Since this time there have been a number of epidemics, notably in Chicago, Boston, Baltimore, New Hampshire, Vermont and New York, and milk as a casual factor has been almost overwhelming in all these cases.

In nearly all these epidemics of septic sore throat the streptococcus was the dominant organism; there were frequent complications or sequelae such as false membrane, otitis media with enlarged cervical glands, arthritis, erysipelas, nephritis and endocarditis. The epidemics spread to various members of a household, school or institution either by direct contact or by means of infected milk.

It is impossible to classify absolutely the clinical complications of septic sore throat from the type of streptococcus involved. The streptococcus hemolyticus of Schottmüller produces angina and erysipelas and as complications lymphangitis, pleuritis and peritonitis. The streptococcus viridans is the most prominent type in the production of endocarditis lenta. Streptococcal infections are spread by direct invasion from the original focus or by the blood or the lymph stream into distant organs. The relation of the streptococcus to infections of the lower

* Read before the Forty-seventh Annual Meeting of the Medical Society of the State of California, Del Monte, April, 1918.

respiratory tract, enteritis and puerpural septicemia is well known. In an epidemic of sore throat in Helsingfors in 1904 in which 2003 cases were studied there were sequellae of erysipelas, otitis media, peritonitis, empyema, mastoid, processes of the antrum of Highmore in the epiglottis region, laryngitis, bronchitis, pneumonia, polyarthritis, acute nephritis, hemorrhagica, oophoritis, neuritis, scarlet fever and infections of the nose and pharynx and adjacent sinuses.

CASE REPORTS.

Case 1. In the Fall of 1916 an epidemic of sore throat occurred in an institution of 200 children in which 30 children were affected. A girl of 16 years, who had never been previously ill, had both strepto- and pneumococci in her throat culture. Though the temperature did not vary between 101° and 103° and the respirations between 36 and 48, her condition soon became alarming. Physical findings were not very well marked. On the fifth day a dullness was noted about two inches in diameter at the angle of the right scapula. An immediate exploratory puncture revealed pus with streptococci in chains of varying length. The left lung showed nothing unusual. Thoracotomy was at once made and the chest was emptied of a liter of yellowish green pus. Her condition did not improve and the following day dullness with bronchial breathing in similar position in the other lung appeared. Another exploratory puncture revealed more fluid with streptococci. Sudden death followed the aspi-

Case 2. Three weeks later a girl of 14 years entered the Children's Hospital with an illness of five days' duration. Six weeks previously there had been a tonsillectomy. Now there were multiple joint infections and infectious nephritis, pericarditis, patches of pneumonia; streptococcal pus was found in the pleura and streptococci in the blood stream. Her death occurred in the sixth day.

Case 3. In December 1917 another case in a woman of 28 years presented practically the same physical findings as Case 1. After a peritonsillar abscess there appeared the same low temperature and double empyema. The pleural fluid was a blood tinged pus present in enormous quantities. Streptococcus viridans was isolated in pure culture. Death occurred ten days from the beginning of her illness.

Case 4. Three days later a child of 2½ years at the Children's Hospital presented a purulent pleural exudate appearing within 48 hours after the onset of a definite pneumonia. The fluid was aspirated, thoracotomy was performed and streptococcus viridans was found. Anti-streptococcus serum was

given and the child is now on the road to recovery after a protracted illness.

Case 5. In January of this year another mild epidemic of sore throat occurred in an institution in the course of which an 18-year-old girl developed a broncho-pneumonia and erysipelas subsequent to a severe tonsillitis.

These cases all occurring in groups within a short period suggested the probability of streptococcus in epidemic form in our community. Since January 15, 1918, I have studied all pneumonias and sore throats in the Pediatric Service of the University of California Hospital, and from other available sources, to determine the prevalence of streptococcus, the type, the clinical findings and virulence. The bacteriological work was done under the supervision of Dr. K. F. Meyer of the Hooper Foundation. In all twenty cases were investigated. The findings are presented in the accompanying table.

The majority of the patients had pneumonia on entrance. In the eighteen cases of infections of the lower respiratory tract (pneumonia, empyema, etc.) fourteen were due to some type of streptococcus. In all of the fourteen cases of primary tonsillitis streptococci were found, in five of which were present this questionable streptococcus mucosus, the others being streptococcus viridans. Some of the cases are especially interesting from the standpoint of contact infection. One, a boy with a lung abscess, secondary to pneumonia produced by the inhalation of a nutshell, showed streptococcus viridans as the prevailing organism in the expectorated pus. About a week later his brother, who had been sharing the same bed, was brought to the Hospital with a streptococcus viridans pneumonia. During my examination of a child with a streptococcus mucosus angina, he coughed into my face. As a result, a tonsillitis and otitis media due to the same organism developed while the nurse in charge of this patient came down with a peritonsillar abscess also due to streptococcus mucosus.

CONCLUSION.

There is no question as to the pathogenicity of the streptococcus and, from a public health standpoint, throat cultures should be examined in severe and questionable cases not only for diphtheria but for streptococcus as well. Streptococcus sore throat

No.	Name	Age	Original Infection	Predominating Condition	End Results	Organism
1	M. P.	Infant	Tonsillitis	Lobar Pneumonia	Recovered	Streptococcus Viridans
2	M. G.	"	"	Broncho Pneumonia	Died	"
3	E. C.	Child	Pneumonia	Otitis Media	"	"
4	J. C.	"	Bronchitis	Pulmonary Abscess	Recovered	"
5	B. C.	Infant	"	Lobar Pneumonia	"	"
6	F. D.	Child	Tonsillitis	"	Died	Pneumococcus Type IV
7	G. H.	"	"	Endocarditis	Improved	Streptococcus Mucosus
8	D. S.	"	"	Pneumonia	Recovered	"
9	A. F.	"	"	Endocarditis	Improved	"
10	F. O.	Infant	"	Lobar Pneumonia	Recovered	Pneumococcus Type IV
11	B. O.	"	Bronchitis	Broncho Pneumonia	"	Streptococcus Viridans
12	C. M.	"	"	Lobar Pneumonia	"	Pneumococcus Type IV
13	R. A.	Adult	Tonsillitis	Otitis Media	"	"
14	C. H. P.	"	"	Peritonsillar Abscess	Recovered	Streptococcus Mucosus
15	C. H. L.	"	"	Broncho Pneumonia	Improved	"
16	C. H. C.	"	Peritonsillar Abscess	Pneumonia	Died	Streptococcus Viridans
17	C. H. Z.	Child	Tonsillitis	Empyema	"	"
18	C. H. L.	Infant	Lobar Pneumonia	Lobar Pneumonia	Recovered	"
19	C. H. R.	"	Tonsillitis	Empyema	"	"
20	G. H. L.	"	Lobar Pneumonia	Peritonsillar Abscess	Died	"
				Lobar Pneumonia	Recovered	"
				Enteritis	"	"

is a reportable disease in New York and has been since 1914. Nurses and other attendants, members of a household, etc., should use all possible precautions to prevent spreading the infection. On reading the medical history of our cantonments and the number of serious streptococcal infections occurring either as sequellae of measles and other contagious diseases or as primary infections one is impressed by the virulence of these bacteria. The methods of investigation at the present time available are by no means as complicated as other routine procedures, the Wassermann reactions for example, and undoubtedly still simpler methods will be evolved as demands for investigation are made upon local boards of health.

the needle is now passed through the apex of the triangular piece, below the skin and at the same level as where the suture emerges from the side wall of the wound; the needle is now inserted in the opposite side wall of the wound, from within outwards and directly opposite to the introduction of the first part of the suture. On tying the two ends the triangular piece is drawn down by the straightening of the buried portion of the suture and permits perfect apposition of the tip of the triangular piece;—preventing the puckering of the tip and giving three straight line wounds for any further suturing, as illustrated in Figure 3.

The suture corresponds to the crown suture in the Emmet operation for perineal repair.

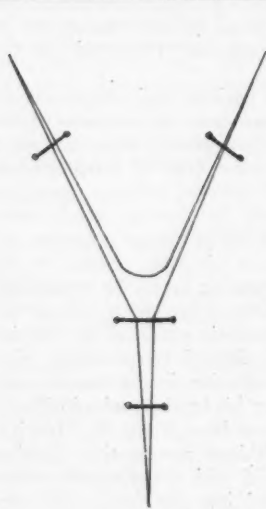


Fig. 1.

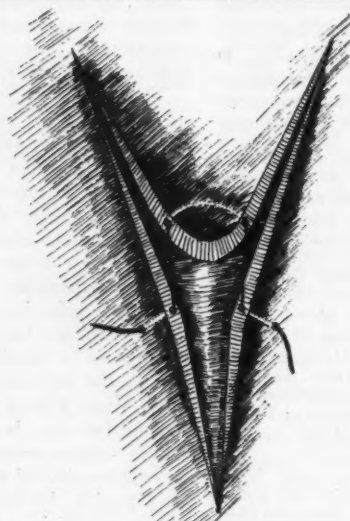


Fig. 2.

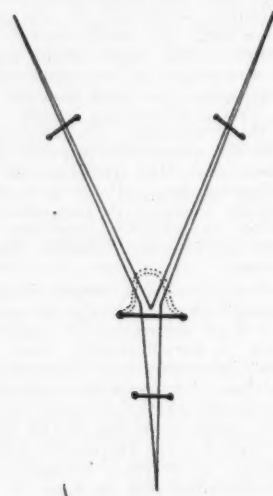


Fig. 3.

A METHOD OF SUTURING "Y" SHAPED WOUNDS.

By J. C. EGEBERG, M. D., San Francisco.

A case of multiple lacerated wounds of the face (windshield accident) came under my care recently where the primary suturing had been done several days before in a country town. The suturing was of the type most commonly used in the closure of "Y" shaped wounds, namely, that shown in Figure 1, and, as a result, the patient has three lumps upon his face that spoil his appearance and will require future plastic work for their correction.

There is always retraction of the triangular piece in "Y" shaped tears of the skin and it is impossible with the commonly used type of suture to overcome this retraction. By the use of a suture placed as illustrated in Figure 2, this retraction is overcome and the apposition is perfect.

The point of the triangular piece is first grasped with tissue forceps and stretched downward in order to determine the point of introduction of the suture. The needle is now put through the skin at the point of branching of the "Y," and is then brought out towards the bottom of the wound;

Wounds with two or more triangular tears are capable of being sewed in the same manner, giving perfect approximation.

Central Emergency Hospital.

INTESTINAL OBSTRUCTION*

With Report of a Case Occurring in a Geophagist.

By HERBERT A. JOHNSTON, M. D., Anaheim, California.

Any part of the intestinal tract may become obstructed and the condition may be termed acute, chronic, or chronic becoming acute. Since it is not purposed in this paper to deal with the incomplete, or chronic varieties, we shall consider only the acute forms of the disease. In this class we find the cases where early diagnosis and prompt relief are paramount to the preservation of the life of the patient.

In order better to understand the causes of intestinal obstruction let us attempt to classify them in regard to the relationship which they bear to the intestinal wall itself. (1) *Intramural*: Such as foreign bodies, gallstones, enteroliths, impacted feces, or anything operating within the lumen of the

* Read at the meeting of the Southern California Medical Society at San Diego, Cal., May, 1918.

bowel. (2) *Mural*: Such as ulcer, gumma, malignancy, paresis, invagination, volvulus, or any pathological condition of the wall itself. (3) *Extramural*: Such as incarceration, mesenteric embolism, strangulation, tumor, or any pathological condition which exists outside of the bowel wall and yet is capable of producing occlusion within it. Obviously there are many conditions which might arise within the abdominal cavity, each in turn being capable of producing intestinal stenosis.

The symptoms of obstruction are not always clear. Those usually found are:

1. Pain—which occurs in about 90 per cent. of all acute cases.
2. Vomiting—usually associated with pain, and generally absent when there is none.
3. Constipation—yet the patient may have one or more movements of feces from below the point of obstruction.
4. Distension—generally a later symptom.
5. Rigidity—associated with pain, and over the lesion.
6. Tenesmus—a fairly frequent symptom in obstruction involving the colon.
7. Tenderness—a very variable symptom.
8. Visible peristalsis—recognizable in patients having thin abdominal walls.
9. Palpable tumor—occurs in perhaps 25 per cent. of all acute cases.

If we could speak of any symptoms as being always present in this malady, our early diagnosis would be greatly simplified, but such is not the case. While all the above symptoms may occur in one instance, there are many others where a diagnosis has to be made from one, two, or perhaps, three of the foregoing. Generally the first three are present early enough for a satisfactory diagnosis, the remaining ones following each other in succession should relief not come.

The early symptoms are modified somewhat by the location of the occlusion, and may be classified as follows, according to whether it is in the upper, ileo-caecal or sigmoidal regions of the intestinal canal.

- | | |
|------------------------------|-----------------------------|
| (1) <i>Upper region</i> | Pain—usually severe; |
| Duodenum. | Vomiting—bilious—not |
| Jejunum. | fecal. |
| Upper Ileum. | Constipation—may not be |
| | complete. |
| | Distension—usually absent. |
| | Tenesmus—usually absent. |
| (2) <i>Ileo-cecal region</i> | Pain—variable. |
| Lower ileum. | Vomiting—becoming fecal. |
| Caecum. | Constipation—after colon is |
| Colon. | emptied. |
| | Distension—gradually in- |
| | creasing. |
| | Tenesmus—frequently |
| | present. |
| (3) <i>Sigmoidal region</i> | Pain—often absent. |
| Descending colon. | Vomiting—often absent. |
| Sigmoid flexure. | Constipation—absolute. |
| | Distension—increasing. |
| | Tenesmus—frequent. |
| | Bloody and mucous stools. |

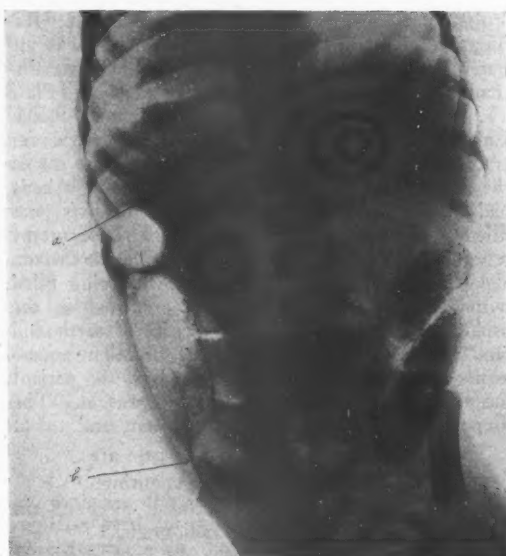


Plate 1.

"a"—Apparent "foreign body" in stomach.
 "b"—Coils of ileum containing sand and earth.

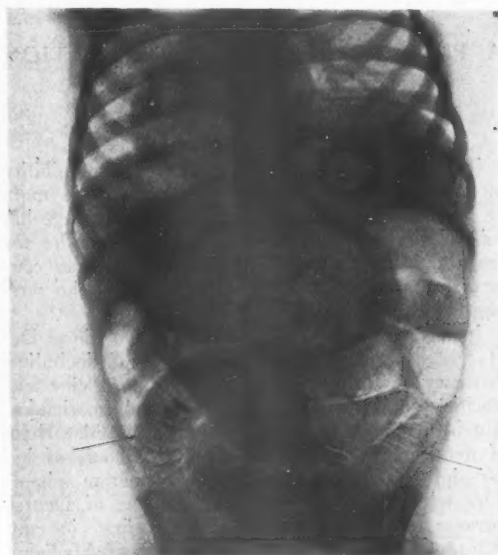


Plate 2.

"a"—Coils of ileum more fully distended and stomach emptied of "foreign body."

From the above it will be noted that pain and vomiting are early symptoms when the obstruction is high and tenesmus with increasing distension are characteristic when it is low. The higher the lesion the more rapid and severe is the course of the disease. The difficulties of early diagnosis will be illustrated by the following case:

V. D., aged two years. Brought to hospital at night, July 29, 1917, apparently quite ill and supposed to have swallowed a piece of tin the previous day while playing on the sand at the beach, as the child was in the habit of eating earth.

Pulse, 96; temperature, 101; respiration, 40. Radiogram of whole abdomen revealed what was apparently a foreign body in stomach and some distended coils of small intestine at caecum (Plate 1). Brown, liquid, very offensive stool at 11 P. M. Enemas during night returned clear except for traces of blood. Another radiogram (Plate 2) in the morning showed that the supposed foreign body had left the stomach and that the pelvis was filled with coils of distended ileum. Laparotomy revealed an invagination of ileum into caecum about four inches in length, the bowel being filled with earth and sand. This was reduced in the usual way. At five P. M. quantities of earth and sand were expelled per rectum. Similar movements continued for the next two days, the patient succumbing on the third day after operation. The supposed foreign body must have been sand.

The outstanding features of this case are:

- (1) The absence of pain and vomiting.
- (2) The history of swallowing a piece of tin apparently corroborated by a radiogram.
- (3) The accumulation of sand and earth at the caecum and lower ileum.
- (4) The radiograms showing coils of ileum though no barium or bismuth had been administered.

A PLEA FOR BETTER CO-OPERATION BETWEEN PHYSICIANS AND DENTISTS.

By C. H. WAKE, D.D.S., Los Angeles.

Those who shoulder the burden of responsibility in the present world struggle are subject to more or less criticism. But after the hysterical stage has subsided and the criticism is based on a desire for truth and justice, then such criticism becomes constructive and not destructive. Just so is the purpose of the criticism which is to follow.

It has been less than a century ago since Dr. Harris conceived the modern idea of including dentistry with the other specialties of medicine and teaching oral pathology with dental mechanics. But being unsuccessful in his efforts to add a chair of dentistry to any of the medical schools of his day, he was forced to establish a separate school. This school was the Baltimore College of Dental Surgery established in 1839—the first in any country. (An Epitome of the History of Medicine by Roswell Park, A.M., M.D.)

As dentistry at that time was in its infancy, being composed almost wholly of mechanical training, it was considered foreign to the science of healing; but the babe has grown and developed into manhood so that it is hardly recognizable.

It is true that the adult "Profession of Dentistry" still retains some of its infant characteristics, but they have been so changed and improved that the infant, as of old, is almost entirely forgotten.

As good environment develops the individual to higher planes, making him more useful to society, so have the scientific teachers of pathology and bacteriology elevated dentistry, the better to serve mankind.

I speak of pathology and bacteriology to the exclusion of others, because it is special pathology of dental origin,—that is the common ground on which the physician and dentist must meet.

In order to best serve our fellowman in the science of healing, there must be co-operation between physician and dentist, inasmuch as pathological conditions, of dental origin, influence the general system in whole or in part.

I quote in part from an article published in the journal of the A. M. A., Dec. 5, 1914, written by Dr. C. H. Mayo, M. D., Rochester, Minn.:

"MOUTH INFECTION AS A SOURCE OF SYSTEMIC DISEASE.

"It has taken a long time for the general public to appreciate the full role of infection in the production of death, while even in the medical profession, more has come from the study of infections in the prevention of disease than in increasing the means of cure of disease, great as have been the results of treatment.

"Since all animal life depends on some other form of cell life, vegetable or animal, it seems but the part of all life to carry on this process of germinative development and maturity.

"It is only the resistance of healthy cells that prevents the inroads of the myriads of ever-present bacteria and animal parasites which are striving to get a foothold that they may in turn carry on their life work.

"Disease, then, is an inflammatory process from infection and the efforts at repair. It may also be chronic from the failure of cell life through lack of defense, from defective nutrition and advancing age."

"Infections which produce the greatest number of diseases enter the system by way of the alimentary and respiratory tracts."

"The great importance of the well-known diseases of the nasal passages with their sinuses, the lymphoid tissue of the pharynx, including the tonsils, and the diseases of the gums and teeth, which have been given prominence by the dental profession during the last three years, is now more generally appreciated."

"Certainly enough is known concerning infections and their mode of entrance, that the infected and diseased mouth and respiratory tract must be looked on as most serious menaces."

"In chronic and recurring diseases, a search must be made to establish positively the non-participation of each of the several sources of infection.

"The physician engaged in this line of observation requires fully as much training in the rudiments of dentistry as the dentist does in the signs of infectious diseases. While we have leaders in all professions, through the energy of their kinetic glands, the big stick which leads to our advancement is in the hands of the progressive and educated public who are constantly demanding more of their dentists, of the medical profession and of

the state in protecting them against preventable diseases."

In view of the fact that when all organs function properly, nature's resistance to the attack of disease is at its maximum, the same law applies to each and every unit of the human anatomy, therefore it is of paramount importance that the dentist, when operating on the teeth, should be ever mindful that the normal function of the teeth and adjacent tissues be not impaired.

Let us consider some of the operations that come under this head.

The treatment of the root canal and its contents, the dental pulp, is the greatest source of trouble of dental origin except it be pyorrhea, with which a physician is concerned, often resulting in the well-known alveolar abscess. The most common of the several reasons are:

Obscurity of factors with which we have to deal; irregularity of size and shape of root canal, making root canal treatment very uncertain without the use of the x-ray. Until more dentists insist that treatment of root canals by modern methods is essential, though more expensive to the patient, this source of trouble will continue to be grave. While there is some excuse for the dentist falling short of an ideal root canal treatment, due to obscurity of factors with which he has to deal, he must be held accountable for all operations contributing to pyorrhea encouraged by lost function of the gingivae, namely, failure to remove from the teeth, calculus under free gum margin; ill-fitting gold crowns; unfinished fillings beneath gum margin; shape of proximal surface, when restored artificially, which becomes a factor of the contact point and interproximal space,—the protection for the septal tissue which in turn is an important resistant to pyorrhea, when functioning properly.

Making large gold fillings in teeth, overtaxing the periodontal membrane by the force of the mallet necessary to obtain the required specific gravity. The same is true of faulty articulation of artificial substitutes for teeth that are anchored to the natural roots, all of which encourage inflammation of the adjacent soft tissue, and in turn contributes to pyorrhea.

The fact that these faulty dental operations are so prevalent throughout the country is appalling, and one who has the interest of fellowman and the advancement of science at heart must look upon the situation with chagrin, in view of the present advanced state of science. It has been my good fortune to gain a vast clinical experience, having been associated with several dental colleges throughout the country as clinical instructor. The dental college is a clearing house for patients who have had failures in their dental operations, who are in search for superior treatment, and I speak authoritatively when I say that in the East, in the Middle West, in the Rocky Mountain region, and on the Pacific Coast, that focal infection is too often the result of poor dentistry.

Please do not understand me to be unwilling to

give credit where credit is due, but, briefly, permit me to add that there are many on the Pacific Coast who are earnestly striving for the truth in dentistry, and bountifully contributing to the advancement of dental science.

So rapid and positive has been this progress that the crown of glory of the Middle West, where the science of dentistry has reached its highest pinnacle, will undoubtedly soon be transferred to the Sunny Southland. This is not only due to the fact that every specialty of dentistry is well represented in our locality, by such authorities in their various specialties as Drs. Edward H. Angle, Julio Endelman, C. J. R. Engstrom, B. B. McCollum, Nye White Goodman, and others, but we have with us Drs. Frederick W. Frahm and Walter G. Crandall, who have been instrumental in placing Iowa at the head of the list in dental science.

Those who have followed the trend of events during the past decade realize full well that the message has been spread broadcast that we should be more thorough in the simple operation of removing calculus from the teeth, and yet, how often do we find this source of irritation under the gum margin that has been overlooked repeatedly during previous cleaning operations. When the average dentist, and it is the average that we must consider, when drawing a logical conclusion,—when the average dentist overlooks such a simple, though destructive factor as calculus beneath the free gum margin, after being repeatedly cautioned to the contrary, it is logical to presume that he may overlook a focus of infection.

Not only is the dentist called on to treat these special pathological conditions, but he must be ever mindful that his dental operations do not contribute to them. The radiograph has revolutionized dentistry; has revealed our shortcomings; has elevated dentistry to heights previously unknown, from the mechanical world to a prominent place in the "Science of Healing." It has brought us in closer touch with the physician.

I wish to quote in part from an article by Dr. David Bernhardt Freundlich, in the January, 1915, *Laryngoscope*:

"THE TEETH AS A PRIMARY FACTOR IN DISEASES OF THE EAR, NOSE AND THROAT—THE DIAGNOSTIC VALUE OF CO-OPERATION OF THE OTOLOGIST, RHINOLOGIST, LARYNGOLOGIST WITH THE DENTIST.

"That the teeth are frequently a contributing factor in pathological conditions of the ear, nose and throat, has long been evident to the rhinologist, laryngologist, otologist and dentist. The fact that the teeth are very often a *primary* factor in such conditions has been more recently recognized by the men of both professions.

"During the last few years, prominent men abroad and in this country have been studying the relationship existing between the teeth and these organs, and many interesting and instructing papers have appeared in the medical journals as a result of their studies. Lermoyez of France, Tilley of London, and B. Frankel of Berlin have contributed valuable literature on the subject."

Dr. Freundlich further cites instances and cases by Bayer of Brussels, Grinwald, Zuckerkandl, Dmochowski, George L. Richards of Fall River, Mass., and many other prominent scientists.

Dr. Freundlich states:

"Before closing, the writer wishes to call the attention of the physician to an interesting report by Dr. C. B. Nesbit, of Valparaiso, Indiana, appearing in a monthly bulletin of the Indiana Board of Health, in 1912. Dr. Nesbit reports a three years' epidemic of scarlet fever in the city, to terminate which, a school inspection was begun. The teeth of 190 children were examined; 937 cavities were found; 454 in permanent teeth; fifty had scarlet fever during the epidemic; 238 cavities were found, one had twelve cavities, two had ten, two had no cavities. After the examination, it was insisted upon that all cavities be filled before the patient is released from quarantine.

"Dr. Nesbit believes with the writer that cavities are incubators for all kinds of pathogenic bacteria. He says, 'Cavities are known to contain the germs of diphtheria, pneumonia, tuberculosis, influenza, and other diseases, which enter the body through the respiratory tract, and as scarlet fever, measles, whooping cough and mumps are believed to be respiratory infections, it is fair to presume that cavities would be equally efficient incubators for these diseases.'

"As a step further in the line of preventive medicine, would it not seem to be the duty of the laryngologist, rhinologist, otologist and dentist, within whose province these incubators of disease lie, to impress upon the patient the great danger to which he is exposing, not only himself, but the community at large, by allowing these cesspools of poison to remain?

"In conclusion, the author of this paper is appreciative of the interest being taken by the men of this branch of the medical profession in the matter of co-operation, and is looking forward to the time when all will meet on common ground for the discussion of conditions relative to their common field of operation and in a relationship as intimately associated as that existing between their professional provinces."

How best can we co-operate with the physician to attain the highest degree of efficiency in rendering the best services the science of healing has made possible?

Diagnosis being the first and all important factor with which we have to deal, we must be sure that no stones be left unturned in locating the seat of trouble, and factors influencing same. While the X-Ray is indispensable in aiding us in our diagnosis of oral pathological conditions of dental origin, it is very limited in its scope of locating foci of infection. Pyorrhea pockets and pericemental abscesses so situated that their relation to the tooth would not show in the Radiograph, therefore, in addition to the X-Ray, the dental diagnostician must be well versed in anatomy, pathology, bacteriology and clinical experience. An extensive knowledge or anatomical

occlusion and operative dentistry aids one in locating the predisposing causes of pathological conditions. In other words, to be forewarned is to be forearmed.

I have tried to show that dentistry has progressed very rapidly, from a mechanical art to a prominent place in Science of Healing; that special oral pathology is the common ground on which the physician and dentist must meet. The welfare of the patient and the progress of the science of healing depends on the co-operation of the two professions.

In conclusion, in order to attain the highest degree of success, in revealing the hidden mysteries of lesions whose foci of infection can be located about the oral tissues, one must not only use the X-Ray, but must acquire all the knowledge that anatomy, special pathology, and bacteriology place at his command.

In view of the previously mentioned facts, it seems logical to believe that the field is broad enough to justify the specialty of dental diagnosis to the exclusion of a general practise.

1004 L. A. Investment Building.

Discussion.

Dr. Bullard: I see many cases of corneal ulcer. The bad tonsils were removed, but the ulcers persisted, twenty of them. The ulcers got well when the teeth were looked after, which really were the foci of infection. I had some fifteen cases of corneal ulcer due to defective teeth. We should co-operate with the dentists.

Dr. Zeiler thinks that focal infection has become an obsession. We should remove focal infection, but tonsils and teeth are often removed without cause. *Streptococcus viridens* is nearly always found at the roots of teeth. There are more than one variety.

Dr. Cline: Sometimes impaired teeth may cause heart trouble. The heart's beat became regular after correcting the faulty condition of teeth.

Dr. Reynolds asked whether the enamel could be damaged by improper scaling. Dr. Wake said yes, but is less likely to be than the cementum which is not so dense, and mentioned the kind of instruments to be used.

Dr. Herbert: A young man became a melancholic maniac, but the dentist could find no teeth at fault. By means of electricity the tooth and abscess were located and removed. The patient was cured.

Dr. Levin: I have diagnosed syphilis by looseness of teeth, excrescences on skull and headaches. The meeting was adjourned.

WAR REFUGEES IN JERUSALEM.

Thousands of Armenian refugees at Port Said and many homeless families in or near Jerusalem are now being cared for by the American Red Cross according to cable advices received by the war council from the Red Cross Commissioner to Palestine, headed by Dr. John H. Finley. The relief work was undertaken at the request of Gen. Allenby, and is being carried on under the direction of the military governor.

The Red Cross has established a general dispensary and hospital with a children's clinic in Jerusalem. Hundreds of persons have already received treatment there. At the request of the government of Jerusalem the organization has taken over two orphan asylums with 400 children. Three hundred Russian refugees are also being cared for in Jerusalem by the Red Cross.

Book Reviews

The Composition of Certain Patent and Proprietary Medicines. By John Phillips Street.

Although the war is distracting our attention from the patent medicine fraud for the time being, we may recommend the above book as a means of obtaining relaxation and diversion. Running through its pages we find a lot of old friends, such as Coke's Dandruff Cure, Hamlin's Wizard Oil and Bowden's Indian Balm. In spite of the times, I presume that human credulity still persists. War brides and old men left at home will resort to some of these infallible remedies as a source of consolation. It therefore behooves every doctor who is able to read the sign posts to get this little directory of "fakirs' delight." It will amuse, instruct and edify. S. P.

Essentials of Materia Medica and Therapeutics for Nurses. By John Foote. Third edition, pp. 310. Philadelphia: Lippincott. 1918.

This book contains tables of drugs, descriptions of the physical properties, physiological action, therapeutics and administration of the more important ones, together with many practical points of value to nurses. It contains chapters on the preparation of solutions and on dosage, tables of poisons and antidotes and other reference tables. It may be recommended as an excellent textbook. L. E.

A Laboratory Manual of Qualitative Chemical Analysis. By A. R. Bliss, Jr., M. D., Ph. G., Professor of Pharmacology, School of Medicine, Emory University, Atlanta, Ga.; formerly Professor of Chemistry and Pharmacology, Graduate School of Medicine, University of Alabama. Second edition, revised and reset, 194 pages with working tables. Philadelphia and London: W. B. Saunders Company. 1918. Cloth, \$2.25 net.

A handy laboratory manual of qualitative chemical analysis and includes the well-known differential tables in a compact form. It may be recommended to students and as a laboratory manual. L. E.

Treatment of Cavernous and Plexiform Angiomata by the Injection of Boiling Water (Wyeth Method). By Francis Reder. Illustrated, 75 pp. St. Louis: C. V. Mosby. 1918.

An interesting little monograph with many excellent plates, some of which are in color. The original article appeared in *Surgery, Gynecology and Obstetrics* nearly three years ago. L. E.

Modern Operative Bone Surgery, with Special Reference to Treatment of Fractures. By Chas. Geo. Geiger. Philadelphia: Davis Company. 1918. Price \$3.00.

This book is devoted entirely to autoplasmic, living bone work; its application in various fractures, in tuberculosis of the spinal column and whenever bone transplantation may be serviceable to reconstruct skeletal deformities. The introductory chapters on the theory of growth and reformation of bone, include the latest research in the histology and histo-pathology of bone and are of intense interest to the student and the bone surgeon. The author criticizes and discourages the use of foreign non-absorbable material, such as metal plates and staples, in bone surgery, and advocates instead the bone transplant and bone graft. A detailed description of the Geiger's motor with attachments and accessories thereto and the exact technic in autogenous living bone transplantation in the manifold conditions mentioned by the author, make the book a very useful and timely addition to the literature of operative surgery. A. G.

The Medical Clinics of North America. Volume 1, No. 6. (The Southern number, May, 1918). Octavo of 224 pages, 35 illustrations. Philadelphia and London. W. B. Saunders Company, 1918. Published bi-monthly. price per year, paper, \$10.00; cloth, \$14.00.

Contents.—J. B. McElroy: Nephropathies. G. S. Bel: Comparison of essential pneumonias from standpoint of clinical significance. Typhoid fever complicated with purulent cerebrospinal typhoid meningitis and no intestinal lesions. C. L. Minor: Artificial pneumothorax (Forlanini). J. S. McLester: Prevention of dissemination of disease. B. W. Fontane: Achondroplasia. Tuberculosis of the peritoneum. Syphilitic fever. C. C. Bass: Malaria. L. T. Royster: Care of premature infant. J. R. Snyder: Ten pellagrins in two families in same neighborhood. J. H. Gibbs: Hodgkin's disease. Reflex gastrospasm. W. H. Deaderick: Malaria. R. Wilson, Jr.: Gonococemia. J. E. Paullin: Myocardial infarct following coronary sclerosis. J. P. Munroe: Severe headaches.

Reclaiming the Maimed. Handbook of Physical Therapy. By R. Tait McKenzie. New York: Macmillan. 1918.

This little volume gives a brief but comprehensible description of physical measures used in the functional reconstruction of body deformities. This application of physical forces, such as electricity, water, light, heat, motion and curative work for the treatment of convalescent soldiers are excellently depicted by the author, who has gathered his experience in Great Britain and Canada while on inspection tours as a medical officer of the United States Army. Muscular reeducation and the measurement of muscle power are described in an excellent article which, by the way, has not had a previous publication. Much valuable information in this rather unfamiliar branch of therapy can be obtained from this chapter. Physical therapy as a science has grown so rapidly since its recognition as a very necessary adjunct in the treatment of war and industrial cripples, that this volume is highly to be recommended as a guide for medical men who deal with cases of injury whether sustained in the field of battle or industry. A. G.

Dental and Oral Radiography. Textbook for Students and Practitioners of Dentistry. By James D. McCoy, D. D. S.; pp. 179. Second edition. St. Louis: C. V. Mosby Co. 1918.

As stated by the author, this book is intended for the beginner in dental radiography. Of particular merit is the clear, lucid style and logical manner in which the basic facts of dental and oral radiography are presented. Although the book is quite elementary, it is comprehensive and covers the discovery of the Roentgen ray, electrophysics, machine types, tube types, technique and radiographic interpretation. The chapter on the technique of handling X-Ray machines and tubes seems to be adapted to the limitations of the old and almost obsolete type of "coil"; it is advisable for the beginner to disregard the procedure given in the book and rely upon the instructions given by the manufacturer of the particular machine used. The author states that a rather high tube (backing up about five or six inches in parallel spark gap) is desirable for dental work. This is contrary to the general practice of those specializing in dental radiography, the preference being for a tube backing up three and one-half or four inches. The back is evidently based upon many years' actual practical experience and is well worth the careful study of the dentist who is interested in this branch of roentgenology. C. O. T.

Surgical Clinics of Chicago. June 1918, Vol. 2, No. 3. Published bi-monthly by W. B. Saunders Company. Price per year, \$10.00.

Contents.—A. J. Ochsner: Renal calculus and gall stones. A. D. Bevan: Kidney stone. Ureteral stone. Cholemia. Ulcerating sarcoma of neck. Fibroma in mesentery at ileocecal junction. Jejunal obstruction from adhesions at site of gastro-enterostomy. G. Kolischer and J. C. Eisenstaedt: Ureteral stone. F. Smithies: Gall-bladder disease (1000 cases). C. Beck: New method of gastrotomy. F. A. Besley: Surgical affections stomach and duodenum. F. G. Dyas: Abdominal tumors and local anesthesia. Hoglund bone transplant for ununited tibial fractures. N. M. Percy: Gasserian ganglion tumor. D. N. Eisendrath: Chest injuries in civil life and war. E. W. Ryerson: Bunions. E. H. Ochsner: Potential and acquired static flat-foot. C. G. Buford: Umbilical hernia in infants and children. R. T. Vaughan: Incarcerated right scrotal hernia. T. J. Watkins: Bicornate uterus. Syphilis with exudates in uterus, etc. G. E. Shambaugh: Surgical affections nose, throat and ear.

Principles of Hygiene: For Students, Physicians and Health Officers. By D. H. Bergey, M. D., Assistant Professor of Hygiene and Bacteriology, University of Pennsylvania. Sixth edition, thoroughly revised. Octavo of 543 pages, illustrated. Philadelphia and London: W. B. Saunders Company. 1918. Cloth, \$3.50 net.

The sixth edition of this valuable and conservative work on the science of hygiene comes to hand with practically the whole volume brought up to date and revised. Necessarily, the chapters devoted to naval and military hygiene must lag behind in the tremendous strides that these branches have made and are making at the present time. But with this single exception, the rest of the volume, devoted to the hygiene of civil life, is a model of thoroughness and can well be used as a reference for all but the most detailed technical purposes. Of especial merit are the sections on industrial and school hygiene and those on the infectious diseases. As a book for the purpose of affording one a comprehensive survey of the whole hygienic field it can be recommended unreservedly.

G. H. T.

Medical War Manual No. 7. Military Surgery of the Zone of the Advance. De Tarnowsky.

This is No. 7 of a very useful series of books. These manuals are compiled by the best authorities obtainable, and contain the essential experiences of our surgeons. For conciseness and direct information they are models. Any one even remotely connected with the war issues of today and its medical phases will do well to have these books in the form of a portable library to serve as his guide and source of information. The chapters taken up in this particular volume are as follows: General Considerations; The Regimental First-Aid Station During Action; The French Zone of the Advance; The British Zone of the Advance; Projectiles; Bacteriology of War Wounds; Traumatic Shock; Hemorrhage; Wounds of the Soft Tissues; General Treatment of Wounds; Tetanus; Gas-Bacillus Gangrene; Cranial Injuries; Wounds of the Face and Neck; Wounds of the Thorax; Wounds of the Abdomen; Wounds of the Bladder and External Genitalia; Spinal Injuries; Wounds of the Peripheral Nerves; Gunshot and Other Wounds of Joints; Special Features in the Treatment of Joint Wounds; Treatment of Compound Fractures not Involving Joints; Splints Used in the Advanced Zone During Transport; Burns; Gas Poisoning; Trench-Foot; Roentgenology in War Surgery; and Treatment of Infected Wounds by Carrel-Dakin Technic. S. P.

Nutrition and Clinical Dietetics. By Herbert S. Carter, Paul E. Howe, and Howard H. Mason. Philadelphia and New York: Lea & Febiger. 1917.

All of the authors are from Columbia University, New York, and are already well known by their writings on fasting (Howe), diet lists for the Presbyterian Hospital (Carter), and pediatrics (Mason). Their combined work results in a practical blending of laboratory findings with clinical experience.

The reader is very properly introduced to the physiology of digestion, followed by chapters on energy requirements of man and a short, but explicit chemistry of foodstuffs. The rest of the book is devoted to specific diets in the different diseases, as well as in infant feeding, obesity, artificial feeding, and presents principally the routine work of later years and approved methods.

The etiological factors, prominent in every chapter, are particularly illustrative in the treatises on diabetes mellitus where text and diagram help to visualize the very maze of glandular stimuli. Carefully detailed and explicit charts serve to simplify the computing of dietaries, i. e., in nephritis, diabetes, obesity, gastric ulcer, typhoid; but no dietaries are included for Army, Navy, hospitals or almshouses, the authors wisely leaving it to the physician's judgment to adopt deductions from foregoing chapters to the requirements of each institution in question. Supplementary tables are attached on food values and Fisher's table of 100 calory portions.

Though not exhaustive, the book is an excellent one for reference and is to be commended for its clear disposition of the various subjects.

M. H. L.

Diseases of the Chest and the Principles of Physical Diagnosis. By George W. Norris, M. D., Assistant Professor of Medicine in the University of Pennsylvania, and Henry R. M. Landis, M. D., Assistant Professor of Medicine in the University of Pennsylvania, with a chapter on the Electrocardiograph in Heart Disease, by Edward B. Krumbharr, Ph. D., M. D., Assistant Professor of Research Medicine in the University of Pennsylvania. Octavo volume of 782 pages with 413 illustrations. Philadelphia and London: W. B. Saunders Company. 1917. Cloth, \$7.00 net. Half Morocco, \$8.50 net.

This latest volume on the diseases of the chest is very exhaustive and most comprehensive. Two hundred and fifty of its pages are devoted to the physical diagnosis of pulmonary and circulatory diseases, while the balance, some eight hundred pages, deals with all the diseases found in the thoracic cavity. The book is too bulky, too much space is devoted to physical diagnosis, making it seem that the volume, which contains such excellent material, is padded for publication. No detail of physical diagnosis is omitted, even to the description of stethoscopes, hammers, and plessimeters. The chapters on pulse tracings, blood pressure, the use of the cardiophymograph and the electric cardiograph, are especially commendable. They are clearly and accurately written, up-to-date, with numerous and splendid illustrations.

Part three of the book, written by Landis, deals with the various pulmonary diseases. We are disappointed that Landis, out of his vast experience, did not give us a personal view upon the etiology of pulmonary tuberculosis. He handles this chapter rather briefly, simply relating the various theories of pulmonary tuberculosis, without committing himself to any one, although if we read between the lines, he rather agrees with his colleague, Paul Lewis, who is of the belief that pulmonary infection in early life has little influence on the disease as it presents itself in adults. It is also

stated that "there can be no doubt that infection in adult life is far more frequent than is ordinarily taught." This is quoted because the statement is at variance with the most recent views of some of our authorities, i. e., pulmonary tuberculosis practically always has its inception in child life. A contrary opinion coming from Landis' pen must certainly be given careful thought and attention.

The chapters on the pneumonias and their complications are very complete and contain the newest work of Cole, Dochez and Avery on typing. We are duly grateful for the chapter on the diseases of the diaphragm as the textbooks give little or nothing on this subject.

The rest of the book is devoted to circulatory diseases with each carefully detailed as to etiology, morbid anatomy, pathology, physiology, symptomatology, and physical signs. The chapters on diseases of the heart are interspersed with excellent pathological and clinical illustrations.

In conclusion the book of Norris & Landis may be commended as an exhaustive treatise on the physical signs and diagnosis of diseases to which the organs of the thoracic cavity are heir. Criticism must be made of the space given to time-worn, well-known and hackneyed subjects, while the personal views of these two excellent teachers of medicine are greatly missed.

W. C. V.

Correspondence

Concerning Physicians and Surgeons College, San Francisco.

San Francisco, Cal., August 24, 1918.

To the Editor:

I have been asked by some of the alumni of the College of Physicians and Surgeons of San Francisco, inasmuch as incorrect rumors are in circulation, to publish a brief statement of the present position of the Medical Department of that institution. In January of this year, I was requested by the Alumni Association and the Board of Trustees to undertake the reorganization of the Medical Department in accordance with the requirements of the State Board of Medical Examiners. This quite onerous task I undertook with the clear understanding that the interests of the student body and the public should be protected by bringing the standard of teaching up to that demanded of an acceptable college according to the requirements of the American Medical Association. To this end changes were made in the faculty, and in the administration of the laboratories and clinics which were considered satisfactory by the State Board of Medical Examiners. The session was lengthened by four months to enable the classes to make good some of the defects they had suffered from during the period of reorganization. How effective this work has been, is manifest by the fact that of the students who have presented themselves under the new conditions to the State Board of Medical Examiners, eighty per cent. have passed. The Board of Trustees very faithfully and thoroughly supported me in the policy of establishing a first class college and spent very large sums of money in improvements. Nevertheless at the end of the summer it became apparent that it was not possible to maintain a satisfactory staff of instructors under the conditions induced by the war. The army took from us Dr. James Eaves, Dr. Lawrence Hoffman, Dr. Bruman, Dr.

Kavanaugh and others in immediate prospect. The department of pathology could only be maintained in a state of inefficiency. Under these circumstances I applied to the Educational Council of the American Medical Association for permission to send the students for enrollment in other acceptable colleges to complete their medical education, the College of Physicians and Surgeons of San Francisco ultimately graduating them on the returns made by such institutions. This permission was granted and the task of continuing their education has been undertaken by the Medical Department of the University of Southern California. This solution of a difficult problem is satisfactory to everyone concerned. Let me state in conclusion and in refutation of statements that have been put in circulation:

First. That the American Medical Association did not refuse to raise the grading of this college under the new administration, for the very good reason that it has not examined it.

Secondly. None of the new faculty severed their connection with the college as a result of dissatisfaction with the conditions. On the contrary the letters of Dr. James Eaves and others were warm in commendation and hope for its future.

Thirdly. The transfer of the students to the Southern College was solely at our instigation and in accordance with the precedent of other institutions.

Fourthly. The success of the teaching of the present faculty is manifest in the returns of the Board of State Medical Examiners, whereby we are credited with passing fourteen students out of seventeen, or eighty per cent—amongst those were two of the highest markings in the examinations.

Very truly yours,

H. D'ARCY POWER,

Dean, College of Physicians & Surgeons.

FROM DR. R. H. HUNT, "OVER THERE" WITH THE NAVY.

July 22, 1918.

... I have had quite a pleasant day. Have been visiting one of the big ships here in the harbor. There were several medicos aboard whom I had met in New York, so we had a good time talking things over. I had gossip that they wanted and they had a lot for me. From a cold storage ship I went to the Corsair, J. P. Morgan's yacht. My, but I was glad that he had so much money to make such a fine boat. She is one of the fastest and largest yachts in the world and I enjoyed my stay there. From there I had a trip by land and sea to this place where I have been assigned to a couple of boats and now on this very good destroyer. Our work has a lot of thrills in it and it is not all comfort. I thought I did not get seasick, but I have changed my mind about that. The things these boats do are wonderful and quick. You think every now and then that the elevator has broken, and sometimes it takes a long drop before it starts back, too. I would get along splendidly as a one-armed man after this training because we always have to have hold of something. I can dress with one hand and eat with one hand and both feet. If I only had a prehensile tail I would be well fixed.

One does not have much medical work to do. It is mostly prophylactic and inspection stuff. If you did get a case you would send it to the hos-

pital, for this is surely no place in which to look out for anyone, nor is it a comfortable place in which to be sick.

Randall is with Army Base Hospital No. 30. It was wet and muddy there, so much so that I was very thankful that I was not in the Army. I don't think much of sleeping on wet ground and standing up to eat. I would rather have no ground and eat with one hand I suppose, but just the same they did not look a bit comfortable.

This place is nearly an Amex city now, even the kids are beginning to throw baseballs through the windows. If they would only quit begging pennies; my, it gets tiresome. . . .

While the weather lasts I will start a letter to you. Everything on a ship of this type depends upon the weather. They discovered me on the yacht and took me away from that nice home. I had quite an interesting trip from the yacht to the ship I was assigned to. Took me a week by land and by sea. No, I was not traveling all the time. I was looking for my trunk some of the while and then had to wait for a vessel to take me on the rest of the journey. In one of the cities I went through there was a large Engineers' camp and I assure you they were doing a lot of work there. The medical work was not very spectacular, no more than it would be around any machine shop or engine yard but it was work that had to be attended to and we all can't be fishing out shrapnel. Though I guess that there is plenty of that to do right now, but the press news is good so that helps a whole lot.

I am now on a destroyer and it is a great life if you don't weaken; if the expression ever fitted, it fits here. I am getting so I could get along with one hand, if I had no other to hang on with. You know what the Fort Bragg bar can do, well we just pray for nice smooth weather like that after we have crashed into a head wind and sea for some 40 hours. This boat slips along at 32 knots and I assure you that is traveling some—I know it is the fastest I have ever dashed along. If the waves don't get out of our way why we just bust into them. Sure I was seasick at first but I am getting used to it now. I want to see the one who does not get sick. When it gets rough you don't get sick, as you are too busy hanging on; there is no sleep, no eat, just jumps and bumps. I have a room up where they keep the paint on most ships and I don't even think you can imagine what it is like there.

The work is interesting, no, not from a medical side, for there don't seem to be much time for that. This is no place for a sick man. The medical work is mostly prophylactic, early and quick diagnosis, so that we can transfer the cases to the hospital. The minor surgery always comes at the worst time when one dare not attempt anything; it gets first aid and when things quiet down gets further attention. I am fleet surgeon, as it were, having a number of destroyers depending upon me. Each of them has a Chief Pharmacist Mate on board and I assure you these men are very fine fellows and are to be depended upon.

To-day we missed something, don't know what it was, but were off in answer to a S. O. S. when we were called back; it wasn't much but then we are ready to take in little bits of excitement once in a while. Not long ago we went to a sinking. The Covington was torpedoed and it was hoped that she could be brought in. We kept the coast clear while the tugs did their best but it was no use, she filled up and went down; no one was lost, but it seemed a shame to see such a fine ship go down. I had been aboard her not long before and was greatly impressed with her greatness and grandness.

Fraternal yours,

R. H. HUNT.

County Societies

ALAMEDA COUNTY.

The Alameda County Medical Association opened the year's work Monday evening, August 19, 1918, with the following program:

- I. Technic of Vaginal Hysterectomy. Illustrated by stereopticon.....By Dr. Chas. A. Dukes.
- II. The Children's Year Campaign.....By Dr. Adelaide Brown
- III. Psychiatric Problems of the War.....By Dr. Jau Don Ball

These papers were both timely and instructive and brought out an interesting discussion by Drs. E. N. Ewer, M. L. Emerson, Anna M. Small, Lieut. A. W. Stearns of the Navy, Major Hutchins, Captains Myers and Orbison of the Army, and August Vollmer, chief of police of Berkeley.

Dr. C. H. Miller of San Leandro, has been elected medical superintendent of the Alameda County Hospital.

The Alameda County Institutions' Commission filed its amended budget for the County Hospitals asking for \$350,000 for the first unit of the proposed new hospital on the recently acquired site in East Oakland. It is proposed to build at once a service building for an ultimate building that will accommodate 250 beds, to cost \$150,000; a surgery and an X-ray laboratory; dressing rooms and pathological laboratory, costing \$50,000; surgical wards and corridors, to cost \$50,000, and a medical ward with sixty beds to cost \$50,000.

Announcement was made at the University of California to-day that Robert T. Legge, professor of hygiene, and university physician, has been commissioned a captain in the Medical Corps of the United States Army and will be stationed at the University Infirmary. The infirmary is being used as the hospital for the School of Military Aeronautics of the University. It will also be used by the Government, according to University officials, as the hospital for the Students' Training Corps to be established at the University, and designated as a semi-military institution.

The following members of the Alameda County Medical Association have entered the service: Drs. A. M. Smith, J. L. Lohse, H. G. C. Boge and E. S. Drucks.

CONTRA COSTA.

At the last meeting of the Contra Costa County Medical Society, Dr. U. S. Abbott, having been commissioned a captain in the Reserve Officers' Medical Corps of the Army, resigned the secretaryship of the County Society, and Dr. P. C. Campbell of Richmond was elected to fill the vacancy.

LOS ANGELES COUNTY.

Personals.

Dr. John C. Copeland has been commissioned captain in the Medical Reserve Corps. He is to go to Fort Oglethorpe, Ga.

Dr. A. Harrison Putnam, who was injured by an auto truck, will recover. He is suffering from a broken rib and from shock.

Dr. C. A. Johnson and wife left for Rochester, Minn., August 11, where Dr. Johnson, having been commissioned captain in the Medical Reserve Corps, will receive instruction under the Mayo brothers.

Film Folk to Build Hospital.

A Home and Hospital for Dependent and Ailing Members of the Motion Picture Industry is planned, demanding an immediate investment of \$300,000 and occupying 60 acres of ground within an hour's ride of the city. It will be offered to the Federal Government as one of the chain of

great military hospitals being founded for the war's wounded. Its capacity will be 500 beds with arrangement for unlimited addition.

David Work Griffith is chairman of the executive board of the Motion Picture War Service Association, Mack Sennett is treasurer, and S. E. V. Taylor, secretary. Thomas Ince, Cecil B. de Mille, J. Gordon Edwards, William S. Hart, Jesse B. Lasky, Mary Pickford, A. S. Smith and Lois Weber are some of the directors. It will also serve as a vocational training school for blind and maimed soldiers and sailors.

Plan for Moron Home.

Dr. George Wallace, psychopathic expert of Wrentham, Mass., presented to the board of trustees a contour map and plans for a State institution for the feeble-minded. The plans provide for a 150-acre site, housing, psychopathic supervision, educational and industrial activities, supervised play and sports and a farm for 120 patients. The buildings are so segregated that all classes of morons, epileptics, delinquents, defectives and low-grade custodials may be supervised in distinctive groups.

180 Los Angeles Nurses on Firing Line.

Miss Edith S. Ryan, secretary of the Red Cross Nursing Service of this city, told of the heroic service of the nurses during the spring offensive when for four days and nights they never slept and never ceased working despite the persistent attacks on hospital after hospital.

Hospital Interns Ask Pay.

The twenty internes of the County Hospital at a conference with the Board of Supervisors, August 26, declared that the county should allow them something, that since their number had been reduced from thirty to twenty their work had increased and that they not only are called on to do work not of an educational character, but they have no time to earn anything outside of the hospital. At present they are given only their board and washing.

Bequeaths \$5,000 to Medical Evangelists.

Mrs. Emilie Hill Scott of Santa Monica, who died August 15, bequeathed \$5,000 to the College of Medical Evangelists, provided that \$1,000 of the sum be used to endow a bed in the White Memorial Hospital, Los Angeles. The estate is estimated at \$75,000.

For Women's Hospital.

An appeal by the Foreign Service Committee, civil and military, that a Los Angeles unit be sent to France by the Los Angeles American Women's Hospital Committee, resulted in reopening its subscription list to increase the fund from \$22,000 to \$50,000. The request came from Dr. Caroline Purnell to Dr. Louis Richter of the Los Angeles Women's Hospital Committee. Subscriptions will be taken at headquarters, 604 Citizens National Bank building.

Protest Negro Nurses.

The Board of Supervisors filed a protest September 3, on the second request from the white nurses at the County Hospital, that a stop be put to the employment of colored nurse students.

MARIN COUNTY.

Whereas, At the next general election Constitutional Amendment No. 26, which provides for the compulsory Health Insurance, will be voted on; and

Whereas, This amendment, if passed, gives the Legislature power to formulate Health Insurance laws of any nature whatsoever; and

Whereas, These laws proposed are indefinite, patterned after the German system, and tend away from democracy; and

Whereas, At the present time, with the high wages and absence of poverty among the wage

earners of California such laws are unnecessary; and

Whereas, An expenditure of fifty millions of dollars will be required each year, and such an expenditure is entirely unjustified at this time when every dollar should be put forward to winning the war; and

Whereas, The sick, under this law, would not be privileged to choose his medical attendant but would be compelled to have treatment from a panel physician inadequately paid, let it be

Resolved, That the Marin County Medical Society, in regular session, go on record as unqualifiedly opposed to this form of Health Insurance and opposed to Amendment No. 26; and be it further

Resolved, That the members of Marin County Medical Society put forth every effort to enlighten the public on this alien amendment and expend every energy toward the defeat of this proposal.

L. L. STANLEY,

J. H. KUSER,

W. F. JONES,

Committee.

September 16, 1918.

MENDOCINO COUNTY.

The July meeting was held on the 27th in the office of Dr. Carol L. Sweet, Elk. On account of the season the attendance was very slim. The discussions, however, were to the point and very interesting. Various letters were read. After the meeting Mrs. Sweet regaled those present with a toothsome lunch.

The August meeting was omitted on account of the invitation for the members to attend—as guests—the meeting of the Pacific Association of Railway Surgeons, held at San Francisco on August 30 and 31. That meeting was a very interesting one, and its program of great import. It and the luncheons were enjoyed and appreciated by all the partakers. Those of the members of this Society who attended are very grateful to Dr. A. Miles Taylor and the P. A. of R. S. for the royal time accorded them. I must not omit to mention the special dinner given by Drs. C. O. Southard and Ethan H. Smith. That dinner will stay long in the memory of the partakers. We certainly all enjoyed ourselves to the limit. No wonder Dr. Taylor—in his invitation—promised us the time of our lives.

To the Medical Profession of Mendocino County:

Duty.

The call is coming, coming near,
For all of us to plainly hear,
That those of us who now steer clear
Must tee the mark, their burden bear.

The call is sounding in the air,
Alike to manly and the fair,
So do your bit, as laid out here,
Be it at home or "over there."

Do no shirking, have no cold feet;
Allow no person hear you bleat.
Be brave—like home upon the street—
When at the front you bullets greet.

Bright are the stars upon our sky,
For Volunteers, where bullets fly.
Do not hang back, for your place try;
Duty calls, don't shirk, don't ask why.

That call is coming, coming here;
Never minding what we hold dear,
To us now calling, do you hear?
No side-stepping, no steering clear.

OSWALD H. BECKMAN.

SAN DIEGO COUNTY.

P. A. Surgeon V. G. Clark, of the Navy, after several months of transport duty is home on leave recuperating. We join with Uncle Sam in hoping that he will shortly be quite fit again.

Dr. A. M. Lesem has succeeded to the superintendency of the Mission Valley Hospital, vice Dr. Joseph Weinberger, resigned.

Major H. Clifford Loos, M. R. C., is now on duty at Camp Kearney after a year's service at posts farther east. His many friends in the southern part of the state will be glad to greet him at the Base Hospital.

San Diego's new Tuberculosis Hospital is now giving service and every bed is filled. It will distinctly enlarge its usefulness to build an out-of-door camp, with funds recently bequeathed to the country for this purpose by private estate.

Dr. O. G. Wicherski is at present convalescing at St. Joseph's Hospital after recently parting with his appendix.

The San Diego County Society resumes its regular semi-monthly meetings Tuesday, September 10th, when it will be addressed by Major Harry M. Sherman, M. R. C., now stationed at Ft. Rosecrans. His subject will be the open-air treatment of surgical wounds. The second meeting of September will be given over to a further discussion of the proposed compulsory Health Insurance Act.

It is with deep regret that we chronicle the recent untimely death of Major William R. Ream, M. R. C., who came to his death while the machine in which he was making observations attempted to alight in a blinding rain storm somewhere in Illinois. Major Ream was one of the few medical men who have as yet qualified as aviators. He was deeply interested in the scientific side of aviation and its demand for certain physical qualifications necessary to its most effective performance. Our Society poet releases the following tribute to the memory of our departed brother:

O Soul Sublime, Brother Physician of Mine;
'T was not yours to only creep, content,
With feet on earth and duty in the skies;
Nor deterred you, the dangers to him that flies.
You, no earth bond could hold,
None other commanded; your only desire,
To be nearest where duty lies
And tend the hurt of your fold.

* * * * *

O Soul Sublime!
May I, like him, learn to fly
And if need be, die, to be near my goal.

H. F. A.

SAN FRANCISCO COUNTY.

During the month of August, 1918, the following meetings were held:

Tuesday, August 13th—General Meeting.

1. Some of the everyday problems of difficult labor. L. I. Breitstein.
2. Newer colloid-chemical studies and medicine. Martin Fischer.

Tuesday, August 20th—Section on Surgery.

1. A form of osteitis deformans simulating syphilis of the bones. S. H. Hurwitz.
2. Posterior dislocation of the inferior maxilla. Sol. Hyman.

Tuesday, August 27th—Section on Eye, Ear, Nose and Throat.

1. Presentation of pictures illustrating operative interference for paralytic strabismus. Hans Barkan.
2. Ocular complications of dengue with report of two cases. Hans Barkan.
3. Sociological and operative treatment of strabismus. Walter Scott Franklin.

TULARE COUNTY.

The regular meeting of the Tulare County Medical Society was held at the City Hall, Visalia, September 4th. A fair attendance listened with great interest to an exposition of the proposed Health Insurance measures to be recommended by the Commission to the next legislature in case the enabling amendment is carried at the fall election.

The Commission has gone into the fundamental questions of sickness as a cause of pauperism and deadbeatism exhaustively and believe that in this measure they will find a cure for more than 60 per cent, and medical experience justifies their conclusions. Details regarding the application of the cure necessarily will need further discussion and the thoughtful consideration of the medical profession.

The bi-county Tuberculosis Sanitarium at Springville is nearing completion.

Plans for a modern, strictly medical County Hospital at Visalia are being considered.

Drs. Chisholm and Fuller of Tulare and Todd of Porterville have entered U. S. service.

Social Insurance

Frequent reference has been made in the JOURNAL to Compulsory Social Insurance, and the advocates of this measure have been given such free opportunity to place affirmative arguments before our readers that we know all will be interested in reading the other side.

The League for the Conservation of Public Health has just issued a folder headed "IT SHALL NOT PASS"—that ably covers the chief points of controversy.

We herewith present it in full.

IT SHALL NOT PASS.

Shall California be the first State to pass Compulsory Health Insurance? On November 5, 1918, this question will confront you on the ballot as No. 20.

Under an attractive disguise, No. 20, Compulsory Social Health Insurance, is trying to gain admittance to its first American State. It has not the American passport. It can not pass muster. It is un-American, undemocratic, unwholesome, unnecessary, unsound, unfair class legislation. It shall not pass. Vote no on No. 20.

1. What is Compulsory Social Health Insurance?

It is a dangerous device, invented in Germany, announced by the German Emperor from the throne the same year he started plotting and preparing to conquer the world.

The proposed law, under humanitarian disguise, would give a Social Insurance Commission arbitrary powers in California and make it superior to and not accountable to courts, executive or people.

2. Why does the Social Insurance Commission, despite persistent requests, refuse to tell the people of California before election, the details of the Compulsory Bill they propose to inflict on the taxpayers of our State?

Because the vast expenditure and the unlimited power of the elaborate political machinery necessary to operate this special class legislation would alarm the people.

3. Has Compulsory Health Insurance been investigated and adopted by any other American State?

Compulsory Health Insurance has been investigated by a number of States. All have refused it admittance as an alien to our shores and an enemy

to our free institutions. New York twice rejected this Compulsory Health Insurance device. The New Jersey Legislature also refused to adopt it, and Massachusetts, after a thorough investigation by two commissions, and with all the alleged facts procured by the Social Insurance Commission of California before it, recently rejected Compulsory Social Insurance in its Constitutional Convention by an overwhelming vote.

4. Are the statements, spread broadcast by the Social Insurance Commission, that sickness and destitution in California are increasing at an alarming rate, TRUE?

Such statements are deplorable and damaging—but not true. California is recognized as the Nation's health resort. Reckless statements to the contrary, based upon partial data, can only have the pernicious effect of reducing our valuable tourist trade.

Reliable statistics show that the average wage-earner in California loses but six days per year from sickness, in splendid contrast to the usual loss of nine days per year in other States. Climatic conditions, working conditions, housing conditions and general living conditions are also superior in California.

5. What will Social Health Insurance do to the working men of California?

It will form the precedent for Compulsory class distinction that will readily be followed by more obnoxious class regulations. In Compulsory Health Insurance we find reflected the sinister purpose of autocracy to establish a dependent class, and make that class dependent upon the arbitrary and compulsory rules of a governing class.

6. Was Compulsory Social Health Insurance proposed by Labor?

Certainly not. It was proposed and imposed upon the wage-earners of Germany by their imperial rulers.

Compulsory Social Insurance does not remotely deal with the equities of labor and wages. It specifically establishes a dependent class of wage-earners and offers to this dependent class poor relief instead of an increase in wages.

Mr. Samuel Gompers, President of the American Federation of Labor, expresses the attitude of those whom he represents as follows:

"The efforts of trade organizations are directed at fundamental things; they endeavor to secure to all workers a living wage that will enable them to have sanitary homes, conditions of living that are conducive to good health, adequate clothing, nourishing food and other things that are essential to the maintenance of good health.

"In attacking the health problem from the preventive and constructive side, they are doing infinitely more than any Health Insurance could do, which provides only for relief in case of sickness, and yet the Compulsory law would undermine the trade union activity."

7. Will Compulsory Social Health Insurance impose an extra and heavier burden upon the taxpayers of California for the "good" of their health?

Yes. The enormous size of this "Compulsory Health Burden" is too heavy for the present treasury of the State to carry. The present total revenue of California is approximately \$25,000,000. It would require twice this amount, about \$50,000,000, to pay cash benefits, give medical, hospital, dental, special tuberculosis sanatorium benefits, etc., to a special limited class of wage-earners and their dependents—and to pay the operators of this Compulsory tax-eating machine.

8. Why is Compulsory Health Insurance called un-American?

Because it retains the characteristics of the land of its origin; it is fitted only to a paternal form of government, where there is discrimination against the dependent classes, and the governing class dominates through class legislation; it is an

arbitrary system of taxation hostile to American principles.

9. Will Compulsory Health Insurance prevent those afflicted with tuberculosis, syphilis, and other chronic diseases, who now reside in various States, from flocking to California to participate in the benefits of this system?

No. As "there will be no medical examination prior to insurance" (according to our Social Insurance Commission) the people of the State can expect all the chronic sufferers, capable of working some part of the time, to take up their residences here as soon as the bars are lowered by Compulsory Health Insurance.

10. Will Compulsory Health Insurance preserve the existing sacred, confidential relations between the physician and his patients?

No. All the ailments, sickness or deformities of the wage-earner or his family will necessarily become part of the public records.

11. Will Compulsory Health Insurance, under the proposed amendment, preserve the inalienable rights and individual liberties of the citizens of this State?

No. The Compulsory Health Commission provided for, holding all power—legislative, executive and judicial—will make you do what "panel" or State doctors decide you ought to do for the general health.

12. Is Compulsory Social Health Insurance an essential war activity?

It may be in its Vaterland, but not in America. All our time, talent and treasure must be exclusively devoted to winning the war. The increasing demands of our boys and Allies, who are fighting the battle of democracy, make the practice of public and personal thrift our patriotic duty, and any indulgence in undemocratic expensive experiments must be checked.

13. What constructive policy for the Conservation of the Public Health do our foremost American health authorities advocate?

A policy devoted to all the people, not to special classes. A policy based upon scientific facts and not dependent upon foreign fads or fiction. **More than 60 per cent. of disease is preventable.**

The practical preventive policy produces permanent results for all. The impractical sickness relief policy of Compulsory Health Insurance would permanently burden the many for the temporary relief of the few.

14. Has this American policy for the Conservation of Public Health, which is so diametrically opposed to the foreign system of Compulsory Health Insurance, demonstrated its superior effectiveness?

Yes; decisively! In the titanic test of the world conflict, in the industrial fields, on land and sea, and in the air, American effectiveness is winning daily triumphs over so-called German efficiency.

15. What are we fighting for "Over There?"

We are fighting for our American birthright—principles of equality and personal freedom—inalienable rights, that we must not forfeit here for this mess of German pottage—Compulsory Social Health Insurance.

16. Is the enactment of Compulsory Health Insurance essential for the improvement of our Workmen's Compensation Laws?

No. Compulsory Health Insurance differs radically from the purposes of Compensation. Workmen's Compensation laws have now been enacted in thirty-seven States, three Territories and the Federal Government—Compulsory Health Insurance has been adopted by none, but uniformly rejected by each State that has considered it. Workmen's Compensation laws aim to provide reasonable indemnity for the loss resulting from personal accidents, which are recognized as inherent incidents and risks of industry. Injuries which occur out of and not in the course of employ-

ment are not included in Workmen's Compensation Laws. Injuries due to intoxication are not covered.

Compulsory Health Insurance, however, would not only award its benefits to the wayward worker who became ill through lax living, secret vices or intoxication, but even if his whole dependent family imitated his vicious example, all of his dependents would be included and given the same indulgent care. The sober taxpayers would pay the bill.

17. Can the Commission guarantee "specialist care" and free choice of Doctor to the individual worker?

No. The insured worker would be limited to the services of the "panel" physician he has selected. His choice would necessarily be further limited to those doctors who are anxious to join the State "panel" and have their compensation fixed by the commission. A system of optional choice, to be effective, would have to place all the doctors under compulsory control. Only that variety of "specialist" who solicits contract practice would care to give special care for \$1.00 per year. In England only the attendance of an "ordinary practitioner" is guaranteed.

18. Will the burden which sickness and disability now impose upon the Nation be relieved by Compulsory Health Insurance in California?

No. But California, instead of being the Nation's health resort, would quickly become a malingering resort for the Nation's sick. Sickness travels from State to State and its results are nation-wide. The question in its larger aspects is national and not local. To adopt a policy of Compulsory Health Insurance on partial data and "assumptions, arbitrary and crude," is dangerous. A comprehensive health survey by a National Health Commission pursuing a preventive, constructive program under the authority of the Federal Government, would economically, systematically and thoroughly deal with the problem of the Conservation of Public Health.

Statement issued by General W. C. Gorgas, Surgeon-General, U. S. A., September 15, 1918:

"The medicine of larger and higher scope is passing perceptibly out of the ordinary bedside phase of diagnosis and treatment to the state in which the little ounce of prevention is at last recognized as bettering the pound of cure."

LEAGUE FOR THE CONSERVATION OF PUBLIC HEALTH.
San Francisco.

Military News

A MESSAGE.

Each day every American soldier in France is confronted by a great duty. Our army there has a great task to perform for our country, for the world, for civilization, and for humanity. Our soldiers are doing their duty with a courage and fidelity and efficiency that thrill every heart.

Each day every American citizen at home is confronted by a great duty, a duty as imperative upon him or her as the duty of our soldiers is upon them. The American people have a great task to perform. It is to support to the limit of their ability our army, our navy, our country at war.

To work with increased energy and efficiency so that our national production may be increased; to economize in consumption so that more material and labor and transportation may be left free for the uses of the Government; and with the resultant savings to support the Government

financially is the daily duty of every American. It is a duty that will be met by every American whose heart is with our soldiers in France, who glories in their courage and fighting ability and their success.

DEATH RATE FROM DISEASE IN AMERICAN ARMIES.

A health rate, which as far as known has never been surpassed, has been established by the American armies both here and overseas. For the week ended July 26 the combined reports of the American Expeditionary Forces and of troops stationed in the United States show an annual death rate for disease of 1.9 per 1,000—less than 2 men per 1,000 per year. The annual death rate for disease of men of military age in civil life is 6.7 per 1,000.

This new rate is based on an approximate strength of 2,500,000 men, and includes men living under abnormal conditions. The overseas record was made while American soldiers were participating in the heavy fighting in the Marne salient, when they were frequently compelled to sleep and eat under the most primitive conditions.

That this record is truly representative of the general health of the troops is shown by the combined reports, which indicate the figure of 2.8 per 1,000 as the average death rate for disease during the past two months.

An idea of the progress being made in military sanitation is gained by a comparison with the following:

During the Mexican War the annual death rate for disease was 100 per 1,000. During our Civil War the rate in 1862 was 40 per 1,000, while during 1863 the rate jumped to 60 per 1,000. The disease death rate for the Spanish-American War was 25 per 1,000.

As far as available records show, the lowest figure heretofore recorded was 20 per 1,000 during the Russo-Japanese War.

Notices

COLLOQUIA.

Colloquia for physicians will be held at the San Francisco Hospital on Thursdays at 9 a. m., in the Surgical Amphitheater, on Surgery and the Surgical Specialties, and on Saturdays at 9 a. m. in the Medical Amphitheater, on Medicine and the Medical Specialties. All physicians who are interested are invited to attend.

The following are the lecturers for the month of October:

Surgery.

October 3—Dr. Emmet Rixford.
" 10—Dr. J. R. Dillon.
" 17—Dr. H. A. L. Ryfkogel.
" 24—Dr. Leonard W. Ely.
" 31—Dr. Leo Eloesser.

Medicine.

October 5—Dr. H. P. Hill.
" 12—Dr. W. F. Schaller.
" 19—Dr. H. H. Yerington.
" 26—Dr. H. E. Alderson.

Very truly yours,

W. OPHÜLS,

Dean, Stanford University Medical School.

NOTICE TO PHYSICIANS.

You are hereby warned against one "Dr. Mann," who upon September 23, 1918, called upon Dr. S. S. Bogle of Santa Rosa and Dr. Jas. W. Sewall of Healdsburg, collecting from each \$2.00 and offering his watch as security in both cases. He claims to

be suffering from diabetes; states that he is a student of Dr. Sayre. His description is as follows: Between 45 and 50 years of age; height, nearly 6 feet; about 170 pounds; smooth shaven; upper front tooth gone; speaks with a foreign accent. He claims that Dr. A. Miles Taylor and Dr. Emmet Rixford of San Francisco sent him to Sonoma County; gives the story of having a sick wife.

State Board of Health

August Meeting.

The regular meeting of the California State Board of Health was held August 3 in Sacramento. There were present Dr. George E. Ebricht, president; Dr. F. F. Gundrum, vice-president; Dr. W. H. Kellogg, secretary; Dr. Edward F. Glaser and Dr. Adelaide Brown.

A Bureau of Child Hygiene was created to be presided over by a director to an appointed by the board.

The resignation of Mr. L. B. Mallory, assistant to the secretary, was accepted, and Mr. Guy P. Jones was appointed to fill the position.

Upon the recommendation of the director of the Bureau of Tuberculosis, the subsidy for twenty beds in the Los Angeles County Hospital was restored, and the action of the secretary in restoring the subsidy to the Tuberculosis ward of the Sacramento County Hospital, effective July 15, was approved. Similarly, acting upon the recommendation of the director of tuberculosis, the board restored the subsidy to fifteen tuberculosis beds in Ward 8 of the San Francisco Hospital, effective August 3.

Acting upon the report of the director of the Bureau of Tuberculosis, the board decided to take up with the surgeon general through the proper channels the matter of making provision for many tuberculous soldiers discharged from army camps who are coming to California, making their care very difficult because of lack of facilities.

Miss Mary B. Eyre was appointed assistant inspector of Schools of Nursing, effective October 1.

Upon resolution of the board, graduate nurses from accredited schools in Utah are admitted to registration in this State without examination, upon complying with the rules and regulations of the board.

Upon the recommendation of the director of the Bureau of Sanitary Engineering, a temporary permit to supply water to its residents was granted to the city of Imperial.

Temporary permits to operate swimming pools were granted to H. A. Hamilton, Saratoga Springs Baths, Bachelor, Lake County, and to the Pacific Electric Railway Company, Los Angeles.

Upon the recommendation of the director of the Bureau of Sanitary Engineering, a permit, under certain conditions, was given to the East Bay Water Company to supply water for domestic purposes to the East Bay Cities.

A permit, under certain conditions, was granted to the city of Martinez to dispose of its sewage into Alhambra Creek, and the sewage of the Fairview section into the adjoining slough.

Licenses to operate cold storage warehouses were granted to the following: Central Cold Storage Company, San Francisco; Central Cold Storage

Company, Eureka; Chico Ice & Cold Storage Company, Chico; San Joaquin Ice Company, Fresno; The Union Ice Company, Stockton.

A large number of food and drug cases then came before the board for hearing.

September Meeting.

The regular meeting of the State Board of Health was held at Sacramento on September 7. There were present: Dr. George E. Ebricht, president; Dr. F. F. Gundrum, vice-president; Dr. Edward F. Glaser, Dr. Adelaide Brown, and Dr. W. H. Kellogg, secretary.

Leaves of absence for the period of the war were granted Stanley B. Freeborn, consulting entomologist, Bureau of Communicable Diseases; Robert N. Hoyt, State district health officer, Central Coast district, and to Frank Bachmann, chief chemist and bacteriologist in the Bureau of Sanitary Engineering.

Upon the recommendation of the director of the Bureau of Social Hygiene, Miss Elizabeth McManus was appointed social service director in the bureau.

Upon the recommendation of the director of the Bureau of Tuberculosis, sixty beds in the San Diego Tuberculosis Hospital were placed upon the eligible list to receive subsidy from the State.

Upon the recommendation of the director of the Bureau of Sanitary Engineering, a permit was granted to the city of Newport Beach to construct sewerage and sewage disposal plants under certain specific conditions; the cities of Covina and Azusa were granted temporary permits to supply water for domestic purposes from the San Gabriel River; a permit was granted to the city of Martinez to make certain proposed changes in the city sewer system under certain specific conditions. Temporary permits to operate swimming pools were granted to the Western Meat Company of San Francisco, and to J. T. Morehead to operate the Modesto Baths. A permit to operate the Meadowbrook Swimming Pool was denied to the city of San Bernardino.

Permits to operate cold storage warehouses were granted to twenty-eight warehouses, scattered throughout California. The regular hearing of food and drug cases was held before the board.

W. H. KELLOGG, Secretary.

Department of Pharmacy and Chemistry

Edited by FELIX LENGFELD, Ph.

Help the propaganda for reform by prescribing official preparations. The committees of the U. S. P. and N. F. are chosen from the very best therapists, pharmacologists, pharmacognosists and pharmacists. The formulae are carefully worked out and the products tested in scientifically equipped laboratories under the very best conditions. Is it not plausible to assume that these preparations are, at least, as good as those evolved with far inferior facilities by the mercenary nostrum maker who claims all the law will allow?

For many years practically all manufacturers of biological products have been supplying Boards of Health with special packages of diphtheritic antitoxins at greatly reduced prices. The difference between this anti-toxin and that ordinarily sold has always been a mystery to the ordinary practitioner. He felt that if the Board of Health anti-toxin is as good as the other, there is no reason for the great difference in price. If, on the other hand, it is not as good, it should not be used. Lately many of the manufacturers have

placed on the market this Board of Health package to be sold indiscriminately at a greatly reduced rate and it certainly seemed of interest to ascertain the exact difference, if any, between the two anti-toxins. Accordingly, three large manufacturers were written to, asking for this information. Their answers left much to be desired. From these answers we learn that the difference in price was originally made because the Board of Health anti-toxin was purchased in very large quantity and was not returnable and, besides, the manufacturers felt that they were doing a public duty in bringing anti-toxin within the reach of every community no matter how poor, even if this entailed an actual loss. As a few firms insisted on placing this Board of Health anti-toxin on the market, others followed, so that the original reasons could hardly hold. The difference between Board of Health and regular anti-toxins seems to be very largely a difference in the volume of the dose, not in its strength. Anti-toxin from different horses varies in strength and it is not practical to concentrate beyond a certain point, therefore the more concentrated is sold as the regular anti-toxin and the less concentrated as Board of Health anti-toxin. There seems to be no definite experiments to determine whether concentration is of any great importance. It is claimed by some that the larger volume injected means a greater tendency to serum sickness and that, therefore, it is advisable to use as small a volume as possible. However, there seems to be no sharp line of demarcation between the Board of Health anti-toxin and the regular anti-toxin but rather a movable standard dependent upon the relative demand for the two. Recognizing the difficulty of maintaining this difference which, at best, seems to be largely artificial, one of the most prominent houses now furnishes diphtheritic anti-toxin in only one style package and this is sold at the price formerly charged for the Board of Health package. If this course is generally followed it will make diphtheritic anti-toxin very much cheaper; it is a question, however, if this is altogether a step in the right direction. It is claimed that with the privilege of replacement and the high cost of distribution diphtheritic anti-toxin will be sold at cost, even at a loss to the manufacturer, and this will, undoubtedly, result in a poorer quality for there is no great inducement to improve a product whose sale is attended with loss. Time alone, apparently, can solve the problem to the satisfaction of all concerned.

Syphilidol is but one of the many preparations offered to physicians as improved substitute for arsphenamine. Every physician knows that salvarsan and neosalvarsan were not perfect, and hopes for something better. However, the improved substitutes will come as the result of careful scientific experiment and will be carefully tested before being offered to the profession. In the meantime the physician should avoid being exploited. Syphilidol is put up in ampoules and in tablets. It claims to be a preparation of arsenic, antimony and silver. The Council on Pharmacy and Chemistry found the tablets to contain $\frac{3}{4}$ -gr. Mercury Protiodide and the ampoules to contain less than 1/5000-gr. Arsenic. Some nostrum makers are taking advantage of the growing friendship for France by advertising preparations said to be largely used in French clinics. Many of these claims are altogether false and the physician should accept them with many grains of salt.

Recent work seems to indicate that the poisonous effects of Arsphenamine are sometimes due to the use of too little alkali in preparing the solution. On the other hand too much alkali seems objectionable causing deterioration of the vein walls. Toxic effects may result from giving the injection too rapidly and it has been suggested that small doses be given first and thus gradually lead to toleration.

New Members

Meads, Romilda P., Berkeley.
Boge, Harry G. C., Oakland.
Grissim, John D., Oakland.
McAllister, Oscar O. T., Oakland.
Small, Anna M., Oakland.
Troutman, Holmes F., Pleasanton.
Krone, Carl R., Oakland.
Hill, W. H., San Francisco.
Jones, Robert A., San Francisco.
Laughlin, C. B., San Francisco.
Watanabe, J., Los Angeles.
McCoskey, Grace, Stockton.
Edwards, S. R., Stockton.
Hoag, Ernest B., Los Angeles.
Johnson, B. W., Fresno Co.
Parrish, Frederick W., Dos Palos.
Wood, Lorin F., Point Loma.
White, Arthur H., San Francisco.
Bransford, S. G., Suisun.
Jenny, Warren C., Vacaville.

Resigned

Burkard, Adrian F., Santa Barbara.
Gould, F. S., Montecito, Cal.
Peterson, Edwin A., Vallejo.

Deaths

Phelps, Carl Elton, a graduate of the College of Medicine, University of Southern California, 1906; died in Los Angeles July 15, 1918.

Kingsley, T. H., a graduate of the University of California, 1886; died in Bakersfield, Cal., June 28, 1918.

Abbott, Edwin K., of Salinas, Cal., died June 11, 1918; was a Fellow of the A. M. A. and a Civil War veteran.

Morrill, Augustus Lincoln, graduate of the University of California, 1887; died in Antioch, Cal., June 23, 1918.

Hopkins, Thos. P., a graduate of the University of California, 1880; died in Potter Valley, Cal., first part of July, 1918.

Boynton, Sumner H., of Los Angeles, a graduate of Hahnemann Medical College, Philadelphia, 1866; died August 2, 1918; age 72.

Douglas, Chas. H., a graduate of Bellevue Hospital and Medical College, New York, 1876; died in Los Angeles August 8, 1918.

Stephens, John Miller, Pasadena, Cal., was killed by the overturning of his automobile near Santa Maria, Cal., July 10, 1918; was a member of the Medical Society, State of California.

Putnam, C. B., a graduate of Missouri Medical College, 1883; died August 4, 1918, age 57, in Napa, Cal.

Nixon, Anne W., a graduate of Cooper Medical College, San Francisco, and a member of the Medical Society State of California, died in Pasadena, California.

Ream, Wm. Roy, San Diego, Calif., a graduate of Sioux City College of Medicine, Iowa, 1902. Licensed in California, 1914, was killed by fall of aeroplane near Effingham, Ill., August 24, 1918.

Brown, Ira E., a graduate of the University of Southern California, 1904, died in Los Angeles August 13, 1918.

Lephakis, John, 233 Post street, San Francisco, a graduate of the University of Athens, Greece, 1899. Licensed in California, 1912. Died in San Mateo County, on the Crystal Springs Road, August 30, 1918.